Tennessee Department of Human Services

ADULT PROTECTIVE SERVICES POLICY MANUAL

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POLICY MANUAL
Adult Protective Services
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Chapter 1
GENERAL INFORMATION POLICY

Introduction

Legislative History and Legal Authority of the Department—T.C. A., Sections 71-6-101—71-6-123.

Tennessee was one of the first states to pass legislation mandating the provision of protective services to adults. General services were provided to adults in the 1960's. In October 1971, responsibility for providing services to adults was transferred to the Social Services staff. All services to adults at that time were voluntary.

With increasing concern for the growing older population, legislation was passed in Tennessee in 1974 which mandated that protective services be provided to those 60 years of age or older. This paved the way for the bill passed by the Tennessee General Assembly in 1978 which provided protective services for all mentally or physically dysfunctional adults in need of such services, regardless of age. Amendments in 1986, 1995, 1996, 1999, 2000, 2001, and 2004 have clarified portions of the law and expanded options available in the provision of protective services.

It is the legislative intent for the Department to protect adults from abuse, neglect or exploitation and that the Department have authority to provide or to arrange for the provision of protective services within budgetary limitations and within the availability of funds appropriated for the general provision of protective services to all persons entitled to those services.

The Department can provide services for persons who request services or, in some cases, when the adult lacks the mental capacity to consent to needed protective services, the Department can seek a court order to provide services to the adult while the adult remains in the home.

If the adult lacks the capacity to consent to protective services and is also in imminent danger of harm, court intervention can be requested to give the Department authority, including custodial authority, to provide necessary services for the adult.

T.C.A. §§ 71-6-101; 71-6-102; 71-6-107; 71-6-109; 71-6-111 and 71-6-112.

It is now possible for the Tennessee Department of Human Services to provide protective services to adults who meet the APS criteria for services and for whom resources are available to provide for those services.

It is also recognized that adult abuse and neglect are social problems which affect the entire community, and the community shares in the responsibility to seek solutions and provide protection to dependent, abused or neglected adults.

Philosophy

The Department recognizes that attainment of the age of majority (age 18 and up), *i.e*., adulthood, is the point at which an individual should have the freedom to determine his / her lifestyle when possible. This rationale dictates that a client at risk must be involved in deciding what plans will be made and what actions will be taken to afford him / her the protection which may be needed. The client needs to understand the options available to him / her and may need to be assisted in obtaining and understanding this information.

An adult has a right to self-determination. At the same time, the law permits the State, through the Department, to protect an adult, to the extent of available resources, when he / she is unable to protect himself / herself because he / she lacks the mental capacity to determine his / her status and he / she is suffering from harm if intervention by the State is necessary to ensure proper care for the adult through social services, medical services and the use of legal services to obtain necessary legal authority to provide those services. Out of concern for an individual's personal freedom, it is important for APS to seek the course of action which affords the needed protection while at the same time encroaches the least upon that freedom.

Protective Services is for adults who are in need of protection and who are dependent on this service to some degree for that protection. Although the quality of life is certainly improved by the availability of this service, improving the quality of life is not the sole purpose of the service. The primary purpose of the service is to address abuse, neglect and financial exploitation. APS supports clients and their families in their efforts to protect the client. APS attempts to maintain an adequate level of safety for the adult. The focus of services is necessarily on "adequate" levels of care.

The Department, in an effort to meet its legal mandate, must guard against interfering with the rights of adults, and offer at least an adequate level of care and safety for those in need of protection. The Department uses the following basic principles to guide planning in protective services:

- To the fullest extent possible, the client participates in making the decision as to the action which should be taken to meet his / her needs.

- The client is helped to remain at home or in the community for as long as his / her condition warrants.

- The action taken should always be the least restrictive / intrusive alternative available which will meet the individual's needs.

- To the fullest extent possible, families, caretakers and other significant members of the informal support system should be involved in meeting the needs of the adult client.

- To the fullest extent possible, formal services should be offered to the client if needed for protection.

- Legal action is only considered after all possible alternatives to legal action have been explored.

- After legal action is taken involving loss of rights to self-direction, they are restored as soon as the client regains his / her capacity to make such decisions. It is not assumed that the inability of a person to direct his / her affairs is permanent.

Functions of Adult Protective Services

Protective services for adults include the following activities:

- Receiving referrals of adults alleged to be in need of protective services;

- Conducting investigations of referrals that are assigned;

- Identifying and assessing the individual's situation and service needs through the use of physical, psychological, psychiatric or social evaluations and consultations;

- Determining levels of safety and danger;

- Counseling with adults at risk or their appropriate representatives;

- Assisting in locating or maintaining adequate food, shelter and clothing;

- Assisting in obtaining required medical care or mental health services;

- Assisting in arranging for conservatorship, commitment or protective placements as needed;

- Assisting in locating or arranging for emergency shelter care;

- Providing legal intervention, when necessary;

- Developing safety plans and or service action plans as needed;

- Assisting with transportation necessary in the provision of these service components;

- Providing advocacy on behalf of the client or the program.

Duty to Report Abuse, Neglect or Exploitation – T.C.A. 71-6-103(b)

Tennessee law provides that "any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made" giving such information to the Department. The law states that death of the adult does not relieve one of the responsibilities for reporting the circumstances surrounding the death.

How Referrals Are Received – Intake Sites

APS has a centralized statewide Intake System. Referrals may be received through phone calls, in writing, fax, electronically or face to face contacts.

Violation of Duty to Report - T.C.A. 71-6-110

Any person who knowingly fails to make a report as required by the Adult Protection Act is guilty of a Class A misdemeanor and upon conviction may be fined not more than twenty-five hundred dollars ($2,500) or imprisoned for not more than eleven (11) months and twenty-nine (29) days or both.

Immunity from Liability for Good Faith Reports of Abuse, Neglect or Exploitation - T.C.A. 71-6-105

Any person making such a report **shall be presumed to be acting in good faith and shall be immune from civil or criminal liability** for such action.

False Reports of Abuse, Neglect or Exploitation - T.C.A. 71-6-123

It is an offense for a person to report to the Department, or knowingly cause another to report, an accusation of abuse, sexual abuse, neglect or exploitation of an adult if, at the time of the report, the person knows or should know such accusation is false. A violation of this part is a Class A misdemeanor. Refer to Legal Policy for additional information.

Confidentiality- T.C.A. 71-6-103

Confidentiality regarding APS records and activities is extremely important and policy adherence is critical. See policy on confidential nature of APS records. Chapter 2- Confidentiality Policy

Continuous Quality Improvement (CQI)

Continuous Quality Improvement (CQI) is an effort to focus on the status of our clients in a measurable way while looking at processes and steps of staff and the larger system to identify and quantify our resource needs. CQI is an effort to continuously change what we can. CQI states outcomes (benefits for clients), looks at process and tasks of staff in achieving those outcomes, identifies challenges, barriers, resource needs, and strives for incremental improvements to help achieve the outcome. CQI is a continuous process in that there is a constant loop of information. Staff is informed about the issues for their unit / region, is able to make changes in local practice or make recommendations for statewide changes, and the changes are then implemented to improve the outcomes for clients.

Chapter 2
CONFIDENTIALITY/ RELEASE OF INDICATED CASE

Legal Authority- T.C.A. 71-6-103, T C.A 71-6-103(d), T.C.A. 71-6-118, T.C.A. 71-6-118(c), T.C.A 71-6-123, T.C.A. 40-35-111

Purpose

To ensure confidentially of all records and/or electronic documents or equipment containing such documents pertaining to APS clients.

71-6-118. Confidential or privileged information; crimes and offenses

(a) The identity of a person who reports abuse, neglect, or exploitation as required under this part is confidential and may not be revealed unless a court with jurisdiction under this part so orders for good cause shown.

(b) Except as otherwise provided in this part, it is unlawful for any person, except for purposes directly connected with the administration of this part, to disclose, receive, make use of, authorize or knowingly permit, participate, or acquiesce in the use of any list or the name of, or any information concerning, persons receiving services pursuant to this part, or any information concerning a report or investigation of a report of abuse, neglect, or exploitation under this part, directly or indirectly derived from the records, papers, files or communications of the Department of Human Services or divisions thereof acquired in the course of the performance of official duties.

(c)(1) When necessary to protect adults in a health care facility licensed by any state agency, such information, reports, and investigations may be disclosed to any agency providing licensing or regulation for that facility; however, the information, reports, and investigations shall retain the protection of subsection (b) when disclosed to such agency and may not be disclosed to, or used by, any other person.

(2) Notwithstanding subsections (a) and (b), the department may report to law enforcement or public health authorities any information from its investigations or records regarding illness, disease or injuries obtained in the course of its investigation.

(d) A violation of any provision of this section is a Class B misdemeanor.

1986 Pub. Acts, c. 630, § 17; 1989 Pub. Acts, c. 591, § 112; 2008 Pub. Acts, c. 1005, §§ 4, 5, eff. July 1, 2008.

Confidentiality Requirements

All records and documents, and information contained therein, concerning adults receiving protective services and reports and resulting investigations of abuse / neglect / exploitation of a vulnerable adult **are confidential**. This includes paper files, reports, records, communications and working documents, computer records, including e-mails, photographs, video tapes, and reports made to the abuse registry, law enforcement and to local offices of the Department.

However, the Department may report to law enforcement or public health authorities any information from its investigations or records regarding illness, disease or injuries obtained in the course of its investigation. This includes adults who are subjects of the investigation, or adults for whom a case may not be opened or to whom protective services may not be provided, or any other persons with whom the APS counselor may come in contact in the course of an investigation. T.C.A.71-6-118(c)(2)

NOTE: Information that becomes part of the APS record as part of a court proceeding when the Department is engaged in litigation is a public record unless the court orders that the record, or parts of the record, be sealed.

Violation of Confidentiality

Any person who releases / shares confidential documents / information in violation of the law:

- Is guilty of a Class B misdemeanor;
- If convicted, may be fined not more than five hundred dollars ($500);
- May, in the discretion of the court, be confined in the county jail or workhouse not exceeding six (6) months;
- May be subject to personal civil liability for violation of privacy.

Confidentiality of the Referent

According to the provisions of the Tennessee Adult Protection Act, the identity of a person who reports abuse, neglect, or exploitation must remain confidential and may not be released unless a court with jurisdiction under the chapter finds good cause for the release of the identity. In such case,

- Immediately contact the Supervisor;
- Immediately contact DHS Legal; and
- Comply with DHS Legal's advice

In 2008, Public Chapter 1005, codified at Tenn. Code Ann. § 71-6-123, made it an offense to **knowingly** make a false report to the Department of abuse, neglect, sexual abuse or exploitation or to knowingly cause another to make such a false report. This statute permits the Department to report to the District Attorney (DA) or other law enforcement authorities the identity of the person believed to have made the false report. A violation of the false reporting law is a class A misdemeanor.

It is important for the Department to use this statute in a prudent and judicious manner. It is also important to recognize that a disposition of an allegation as unsubstantiated or a classification of an investigation as invalid **does not** mean that the referral was falsely reported. To be a false report subject to the criminal sanctions, the person reporting the abuse must have known it was false when the report was made. A report made in good faith, but which ultimately is unfounded, is not grounds for criminal prosecution.

Process for Release of the Name of the Referent of False Report to the District Attorney

In the event APS staff believes a referent has knowingly made a false report or has caused another to do so, the following steps should be taken:

- The FS1 and HSPS should review the referral(s) and case information as well as the documentation supporting the counselor's belief that the report was knowingly false.

- If there is a reasonable belief that the referent has knowingly made a false report, the matter should be sent to APS State Office for further review.

- If APS State Office agrees that the referent has knowingly made a false report, the matter will be relayed to DHS Legal for review.

- When warranted, DHS Legal will make a referral to the District Attorney or law enforcement.

- **Under no circumstances** should anyone other than DHS Legal provide the name of the referent to the District Attorney or other law enforcement.

Release of APS Investigation Information

Release of information from APS records should follow the principle that **only** the amount of information necessary to obtain services or other assistance for the adult or to obtain information necessary for the investigation of A/N/E allegations and for the provision of protective services should be released. Release of all, or

substantial portions, of a record is not appropriate except in circumstances where it is absolutely necessary to do so and with TDHS Legal approval.

APS may release information to:

- Service providers who are involved in delivering services to the client when the sharing of information is necessary in order to provide protective services to the client and is in the best interest of the client.

- Professionals who are providing case consultation when the sharing of information is necessary in order to provide protective services to the client and is in the best interest of the client.

- Individuals involved in the case when the sharing of information is necessary to obtain information related to the adult's circumstances and in order to provide protective services to the client and it is in the best interest of the client to do so.

- Any agency providing licensing or regulation for the facility when necessary to protect adults in a health care facility licensed by any state agency. When disclosed to those agencies, the information, reports, and investigations retain the confidentiality protections of T.C.A. § 71-6-118 and may not be disclosed by them to, or used by, any other person.

- Law enforcement, including the TBI and the District Attorney, who must receive notice of the receipt of a report of harm or who are involved in the investigation of the possible abuse, neglect, or exploitation of an adult. T.C.A. § 71-6-103(d) (1). Law enforcement includes municipal law enforcement; county sheriff's departments and their investigative / detective divisions; investigators with the DA's office, U.S. Attorney's office and their military counterparts. Information regarding a case involving the Department may be shared with the State Attorney General's Office.

- APS staff who have a need to know.

- Multi-Disciplinary Teams in the course of presenting a case for consultation. New members of these teams must be instructed on the confidential nature of the APS case information and the criminal statutes prohibiting its release except for the administration of the APS law.

- Tennessee Department of Mental Health when involved in an investigation of a mental health care facility licensed by that Department and when the sharing of information is necessary in order to provide protective services to the client and sharing information is in the best interest of the client.

- Tennessee Department of Intellectual and Developmental Disabilities (DIDD) when involved in an investigation a facility licensed by DIDD and when the sharing of information is necessary in order to provide protective services to the client and sharing information is in the best interest of the client.

- Law enforcement and public health authorities in order to report to them information regarding illness, disease or injuries, provided that such information is obtained in the course of an APS investigation.

- Teletype writer (TTY) when needed to provide protective services to a client who is deaf or hard of hearing and it is in the best interest of the client. Telephone relay operators are bound by confidentiality.

- Interpreters / translators when needed to provide protective services to the client who speaks a different language so long as the interpreter / translator is bound by a code of ethics that requires the confidentially of APS information to be maintained.

- The referent as permitted by law to provide an update regarding the outcome of investigation with respect to the client's need for protective services. T.C.A. § 71-6-103(d)(5). Again, only the minimal amount of information necessary to convey the outcome of the investigation should be provided, and no other details of the case should be disclosed. Refer to Chapter 5 for specifics regarding personal information that can be released.

In **no** case, shall **the information shared include the name of the referent**, including when sharing the 1215 Form, except as otherwise specified above.

Note: If there is *any* question about what information should be released and to whom, DHS Legal must be consulted.

Release of Information Requiring DHS Legal Approval

If a request for information is made for any purpose not directly associated with the investigation of the abuse, neglect or exploitation of the adult, the information cannot be released without review by DHS Legal for an exception that may allow disclosure. Upon obtaining DHS Legal approval, APS may release information, excluding the name and identity of the referent to:

- Law enforcement.

- A court, other than the court with jurisdiction over the APS case.

Note: In the normal course of presentation of the APS case to the court, we will provide information from the APS records at the direction of DHS legal staff as part of the court case. However, a court order to release the name of the referent or a subpoena or other legal document served by any persons not associated with the Department or the APS action seeking copies of the APS record must be referred immediately to DHS Legal for evaluation.

- Grand Jury, by subpoena.
- Attorney / Guardian ad litem assigned to the client.
- Other persons as ordered by the court.
- Other state or federal agencies investigating cases of vulnerable adult abuse or neglect.
- Other state or federal agencies requesting information about an APS case when they are seeking to determine if there is an APS case on a client in Tennessee, and the other agency had received an APS related referral in their state, or who need assistance in providing assistance to someone in their state for whom they are providing APS services.

Use of Confidential Information Obtained From Another Agency or Professional

Any information obtained from another agency or professional, the confidentiality of which is protected by another statute, may not be used except as it may be necessary to carry out the provisions of the Adult Protection Act or as authorized by the respective statute governing the confidentiality of that information. T.C.A. § 71-6-103(j)(5).

NOTE: If there is a question about the confidentiality or use of information, legal advice from the DHS legal staff must be requested.

Release of the Identity of the Perpetrators to Employers or Licensing Agencies

Release of information about an alleged perpetrator involves issues of civil rights regarding his / her employment status or his / her ability to hold a license necessary to provide services to adults.

NOTE: Refer to Chapter 20 for Due Process procedures.

Due Process Requirements

The indication of an individual as a perpetrator of abuse, neglect, or exploitation first requires a thorough investigation, assessment, classification of the evidence by APS staff. After making an indication, due process must be provided to permit the alleged perpetrator to contest the finding and intended, or emergency, release of information by the Department identifying him / her to his / her employer or licensing authority as an indicated perpetrator of abuse, neglect or exploitation of an adult.

Due process may involve either:

- An administrative due process procedure that is established by rules adopted by the Department; or

- Civil court action taken by the Department for a TRO or temporary / permanent injunction, in which the court finds that the alleged perpetrator has committed abuse, neglect or exploitation of an adult and in which the court enters an order prohibiting contact with the victim or other potential victims in an institutional or facility or other caretaker setting; or,

- Civil court action taken by the Department for a TRO or temporary / permanent injunction in which the court has conducted a final hearing on the evidence and has made a finding that the named defendant in the APS complaint is the perpetrator even if there is no injunction or TRO issued.

- Criminal court action against the alleged perpetrator initiated by law enforcement and/or by the district attorney that result in a conviction or guilty plea for an offense that comprises the elements of abuse, neglect or exploitation.

EXCEPTION: When the investigation, assessment and classification indicates a caretaker as a perpetrator of A/N/E, and it is determined that it is necessary to release the information immediately because the facts constitute an immediate threat to the adult or other adults who are, or may be, under the perpetrator's care, information identifying the person as a perpetrator can be immediately released to the employer or licensing authority in order to protect the adult(s). In this situation, the perpetrator will be notified of the emergency release and will be given an opportunity to contest the finding after the release.

The Department's legal staff must be consulted prior to the dissemination of a finding that a person is an indicated perpetrator of abuse, neglect or exploitation of an adult.

NOTE: Refer to Chapter 20 for a Due Process Indicated for paid caretaker.

Chapter 3
ETHICAL ISSUES IN APS POLICY

Legal Authority

T. C. A. 71-6-107(a)(6), T. C. A. 34-11-101, et. Seq., T. C. A. 39-16-401

Purpose

The mission of Adult Protective Services staff is to protect vulnerable adults from abuse, neglect or financial exploitation. The population APS protects is by definition vulnerable (impaired, dependent, unable to protect themselves). All APS staff has a duty to avoid financial, business, personal or other relationships which might compromise the public's interest or cause a conflict with the performance of their duties. Adult Protective Services staff by the nature of the work they do must have the highest ethical standards as identified in the Employees Code of Ethics.

Policy

Criminal and Civil Actions

Any DHS staff person who improperly disposes of a client's property or resources can be subject to charges of theft or fraud as well as civil litigation seeking recovery of property or funds improperly taken or received from the client. Additionally, the law governing official misconduct by government officials (T.C.A. § 39-16-402) states that a government employee who uses his / her position for profit or gain may be prosecuted for a Class E felony.

Handling Client's Property / Possessions

There are two basic rules to follow when handling a client's property / possessions:

1. APS staff is never to profit or gain from any contact with an APS client or from access to his / her property, possessions, resources, funds, etc.

2. It is important to avoid even the appearance of a conflict of interest in contacts with APS clients, or access to their property, possessions, resources, funds, etc.

There are two (2) primary types of situations in which the access to and handling of a client's property / possessions may become an issue. These situations are:

- Cases in which APS is involved in legal action to place or remove a client under the protective services program, or

- Cases in which APS is investigating, assessing or providing protective services to a client but legal action has not been initiated or planned.

Guidelines

These guidelines apply to all APS clients – clients with substantial amounts of real or personal property, or substantial liquid resources in a financial institution, as well as those with only modest personal possessions.

The APS focus is on the safety and welfare of the individual. APS does not want to assume responsibility for belongings or funds of clients. However, there are times when the client's well-being may, to some extent, be affected by what happens to their possessions or other resources.

Cases Involving Court Intervention

Take the following reasonable steps to secure property / belongings:

- If there are no other options available and APS staff have to take possession of any client's property / belongings, maintain a clear paper and/or witness trail to track the items and what is done with them; and report possession of any property to your supervisor immediately, describing in writing exactly why taking control of the assets was required and exactly what has been taken into possession.

- Signed receipts or written statements are critical in maintaining a system of documentation and tracking and should be scanned into the automated system and attached to the client record.

- Discuss with a DHS attorney actions to take to protect, secure or dispose of any property belonging to an APS client. Legal options include:

    - Requesting a temporary guardian to be appointed if the client has sufficient resources to defray the costs of care in a case involving DHS legal intervention seeking to provide protective services;

    - Requesting a conservator to be appointed under the conservatorship law if the requirements stated in the Legal Practice Guide are met. Appendix F; or

    - Temporary / Permanent Injunctions or Temporary Restraining Orders.

- A court order should be requested, when possible, regardless of the value of the personal property, in order to direct the disposition of the property / resource.

APS Access When Court Action is not planned

APS staff should avoid having possession of the property, possessions, or resources or funds of a client. In those situations in which it is necessary in order to protect the client, or in an emergency situation, use the two basic rules regarding clients property and possessions and take all safeguards to avoid the appearance of a conflict of interest and report to the supervisor in writing immediately your possession of the client's property and reason that it came into your possession. This information should be documented in the case record.

Handling Clients Property/Possessions When Client is Leaving the Home

When deciding the best action to take regarding handling of the client's assets:

- Ask the client what they want done (specific ideas or preferences).
- If possible, obtain preferences in writing or with a non-DHS witness present.
- Secure the home, apartment, papers and valuables to the extent possible.
- Maintain any keys in a safe location or give to the ambulance attendant if client is going to the hospital. Contact the supervisor and document in the record. Have client sign a release.
- Encourage the client to take any important papers with him/ her and request that they be tagged and locked up (if possible), *i.e*., hospital, nursing home, etc.
- If DHS has a means of storing any items and consideration is given to doing so, then list all items and have a second party sign the list. Two DHS staff persons must sign as receiving the items and two staff persons must also sign when the items are returned.
- Ask the DHS attorney to draft a release of liability statement for the client to sign.
- Identify other service providers, or DHS volunteers, who may be able to assist. Having a different agency involved will reduce the potential conflict for DHS.
- If a client dies while any of his / her property is in our possession, notify the DHS attorney. Disposition of this property will be determined by the court.

- APS counselors must ensure and document that their supervisors are aware of any cases in which a counselor has or needs to have access to the resources or property of an APS client.

- Notify the police if the client's home is going to be vacant for an extended time.

- Ask police to be present and assist in securing property.

- Ask management level staff of the local DHS office to assist in documenting, witnessing or securing possessions, or arranging for the assistance of a registered volunteer.

- If a client leaving the home has pet/pets, the counselor should attempt to make arrangements for the care of the pet.

    - Call law enforcement to assist

    - Call the local animal shelter or animal control

    - Contact family/friends to assist

Handling Clients Property/Possessions When Assisting the Client Who Remains in the Home

APS staff will make every effort to avoid handling the money or property of clients, even in emergency situations. If at all possible, a trusted family member, neighbor, friend or appropriate service provider should be identified to assume this responsibility. Social and/or recreational activities are never reason for APS staff to handle client's money, property, etc.

When it has been determined that there are no available alternatives, APS staff may handle the client's money or property in the following limited situations:

- There is an emergent need to address a situation impacting the client's immediate welfare and/or safety, such as the need to purchase groceries or medication, etc. or pay a utility bill.

- The client is unable to perform the task even with assistance from APS staff.

- There is no other reliable person available to take this responsibility.

The following safeguards will be followed when handling the client's money or any possessions, etc. to ensure that there is no conflict of interest, profit or gain from the activity, or the appearance of profit, gain or conflict of interest:

- Supervisory approval must be obtained before undertaking any activity that involves handling the client's money or property and documentation of that approval must be included in the case recordings.

- Prior to giving approval, supervisors must explore every possible alternative with the Social Counselor.

- Any money handled (cash or checks) must be for the express purpose of paying a crucial bill (for instance, the utility bill in the winter time) or purchasing vital commodities for the client. Record exactly what was purchased and retain receipts for all purchases. Give the client a copy of the receipt and maintain a copy for the case record.

- APS staff **cannot** utilize a client's debit card or EBT card, credit card or any other card that requires a PIN number.

- Obtain a statement for any cash, etc. received from the client that includes:

    - the amount given by the client,

    - the name of social counselor,

    - the name of business or merchant,

    - purpose – the product or service obtained,

    - the dollar amount returned to the client,

    - the date and signature of the client. (See sample **Client Statement** below).

- A copy of the signed client statement and copies of all receipts are to be placed in the client's record.

    - If a utility bill is being paid, the stamped receipt shall be returned to the client.

    - If groceries or medications are being purchased, the itemized receipt shall be returned to the client.

    - The cost of the items purchased and the change returned shall exactly correspond to the amount of money which was initially received.

- Checks shall be made out to the business or merchant — never to cash or to APS staff.

- APS staff shall never accept or purchase from the client or others involved in the case, a gratuity, either in cash or in kind, no matter how small. Staff shall NEVER accept anything from the client.

Note: If a client is in need of a small amount of groceries on an emergency basis, the Social Counselor may purchase food with the Counselor's personal funds and receive reimbursement from the State by including the expense on the travel claim.

All actions regarding the handling of client funds or property must be recorded in the case record.

Relationships with Client

It is important for APS to conduct themselves as professionals not only in open APS cases, but also in closed APS cases. Due to the nature of the clientele and issues involving social work, it is not uncommon for clients to develop a dependency on APS staff. Due to the population that is served by APS, APS staff may be the primary contact for the client for support. However, it is critical for APS staff to understand that the relationship is professional and not personal. This dependency often results in Counselors receiving calls from clients in closed cases asking for assistance. In order to protect the integrity of the Counselor and the Department of Human Services, the APS staff must not:

- Initiate continued contact with a client once the case is closed,

- Authorize services on a closed case,

- Provide any type of activity on a closed case without permission of the supervisor,

- Sign any legal document as POA, Healthcare Advocate or in any other capacity on behalf of the client on open or closed cases,

- Discuss with the client any of the Counselor's own personal issues,

- Be allowed on-going access to a client's home in the absence of the client.

The key issues to be answered when performing the duties of a Counselor are:

- Is the activity to be performed in the scope of employment?
- Could the activity give the impression of conflict of interest or unprofessional behavior?

Violation of this chapter will be Grounds for Disciplinary Action.

SAMPLE STATEMENT FOR HANDLING CASH, RESOURCES, ETC.

(Cash / check) in the amount of $ _____ was given to

_____ by _____

for the (purchase / payment) of _____.

A receipt for the transaction in the amount of $_____ was provided

to the client along with change in the amount of $ _____ and

the items purchased.

_____ _____
Client's Signature Date

_____ _____
Counselor's Signature Date

_____ _____
Approved by (Supervisor) Date

Verification must be maintained in the case file.

Chapter 4
INTAKE POLICY

Legal Authority

Adult Protection Act, T.C.A. §§ 71-6-101 et seq.

Purpose of Intake

The purpose of intake is to manage information regarding referrals alleging abuse / neglect or exploitation or risk of abuse / neglect or exploitation of vulnerable adults who are unable to protect themselves; to enter the information into the computer system; screen referrals to ensure that threats to the safety of a vulnerable adult are effectively identified, that information reported meets the criteria for APS intervention, an appropriate response priority is assigned, and referrals are forwarded to appropriate APS personnel for investigation / assessment.

Policy

The Role of Intake

- Intake counselors must be scheduled, logged into the Intake telephone system and in an available status to receive referrals alleging adult abuse, neglect or exploitation on each business day from 8:00 am to 4:30 pm Central and Eastern Time.
- Intake staff must be available to take referrals by fax, electronically, telephone, in writing or in person.
- Intake staff regularly and appropriately distributes and responds throughout the day to messages left in the APS referral e-mail account, based on established protocol.
- Intake staff will receive, record and enter into the APS system referrals from all referents including those who are anonymous and/or who do not have direct knowledge of the incident being reported.
- Intake staff will treat all referents in a professional and courteous manner, remaining objective and non-judgmental.
- Intake staff shall not put an intake call on hold to answer a personal call.
- Intake staff will record as the date and time of the referral the time at which the call was answered, not the date and time at which the intake counselor began documenting the referral information.

- In the event a referral is received via fax, electronically or by voicemail, the referral shall record the actual date and time we received them.

NOTE: the Intake Supervisor must ensure that:

- They are logged into the Intake Telephone System at some point each work day in order to periodically monitor incoming calls and coverage, unless circumstances prevent the accessing of the Intake Telephone System (*i.e*., in training, at a conference, out in the field).
- Intake staff shall have access to an intake supervisor at all times.
- Intake Telephone System is monitored to ensure sufficient staff is available between the hours of 8 am to 4:30 pm Central and Eastern Time to answer calls.
- The calls / messages stored in the Referral mailbox have been opened, reviewed, and responded to, if necessary, by the end of the work day.
- Intake staff are using their time efficiently and in a way that provides the most accessibility to the public
- Intake staff are controlling and directing the interview process. The capability to monitor and review the intake calls shall be utilized by the supervisor to improve the quality of the intake experience

Criteria for APS Involvement

Intake staff will gather sufficient information to determine if the referral meets minimum criteria for assignment and investigation. To be accepted for APS intervention, information from the referent must meet all the following criteria;

1. The alleged victim must be age 18 or over.
2. The alleged victim must have some type of impaired functional status that prevents him / her from protecting him / herself and there are no other available individuals to assist them.
3. Open case on a deceased individual if others may be at risk.

   The functional impairments are:

   Mental Dysfunction – Mental impairment is any mental disorder such as an intellectual disability, organic brain syndrome, emotional or mental illness which makes the adult, in whole or in part, unable to care for his / herself, dependent upon others for care and daily living or should be dependent upon others for care and daily living, and/or unable to comprehend the consequences of his / her decisions and/or the nature and consequences of remaining in a situation of abuse, neglect or exploitation.

Physical Dysfunction - The alleged victim is physically unable to:

- Protect him / herself from neglect, hazardous or abusive situations;
- Take care of basic needs such as personal hygiene (bathing), necessary shopping (food) bill paying (utilities), food preparation or obtaining required medical care.

Frailty due to aging – An alleged victim who is 60 years of age or older and is

- Unable to manage his / her own resources
- Unable to carry out the activities of daily living,
- Unable to protect his / herself from neglect, hazardous or abusive situations.

NOTE: *Mental dysfunction, physical dysfunction or frailty due to aging that is reported does not* ***automatically*** *result in an assigned referral.* ***There must be a description of how that status prevents the adult from protecting or providing for him / herself.***

3. There must be an allegation that the alleged victim has been abused, neglected or financially exploited or is self neglecting, **or is at risk** of being abused, neglected or financially exploited or self neglecting. Financial exploitation, physical abuse and neglect must be by a caretaker. "Caretaker" means an individual or institution that has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement.

Exception – If the allegation is sexual abuse and the alleged victim meets the first 2 criteria, the relationship/role of the alleged perpetrator is immaterial. The alleged perpetrator does not have to be a caretaker.

Allegation Types

Severe Abuse is defined as: ***Any abuse which requires immediate medical attention to treat conditions that could result in*** **irreparable** ***physical harm or any sexual abuse.***

NOTE: This could also include neglect that is so severe that immediate medical attention is required or neglect that could result in irreparable physical harm.

a. **Abuse**

Abuse is the commission of an act to cause physical pain, physical injury, mental anguish, emotional trauma or inappropriate / unreasonable confinement, by a caretaker, of an adult who is unable to protect his / herself. Abuse may include, but is not limited to the following:

- Injuries which are debilitating or, if not treated, would become debilitating;
- Conditions which would cause permanent disabilities; or conditions which would be considered terminal if not treated; or
- Injuries that are inconsistent with the history given; or
- Injuries for which there is no reasonable explanation.

b. **Sexual Abuse**

Sexual abuse occurs when an impaired adult is forced, tricked, threatened or otherwise coerced into sexual activity, involuntary exposure to sexually explicit material or language or sexual contact against the adult's will. Sexual abuse also occurs when an adult is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person. Sexual abuse provides grounds for the Department to obtain custody of an adult who lacks capacity to consent when such abuse relates to sexual activity or contact. This includes, but is not limited to:

- Sexual contact that may include physical and emotional abuse and verbal harassment of a sexual nature.
- Sexual abuse that occurs regardless of whether or not the perpetrator is the spouse of the victim.
- Sexual contact between an authority figure and an adult who lacks capacity.

c. Neglect

Neglect is the omission by a caretaker of services / care needed by an adult to prevent physical or mental injury/illness,

"Caretaker" means an individual or institution that has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement. A financial institution is not a caretaker of funds or other assets unless such financial institution has entered into an agreement to act as a trustee of such property or has been appointed by

a court of competent jurisdiction to act as a trustee with regard to the property of the adult.

NOTE: ***Intent*** by the caretaker ***is not a*** factor in determining neglect of the adult.

d. **Self-Neglect**

"Self-Neglect" is the result of an adult's own inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: obtaining essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs." (Definition provided by the National Association of Adult Protective Services Administrators, October 1990)

NOTE: Neglect **and** Self-Neglect may both contain, but are not limited to, the following circumstances:

1) **Medical Neglect**

Medical neglect may include situations in which:

- Caretakers have failed to seek needed medical care for an alleged victim.
- The alleged victim has failed to obtain such care for him/herself.

The needed medical care is believed to be of such a nature that failure to provide medical care is likely to result in physical or mental injury / illness if such care is not provided. Medical care may include the services of physicians, nurses, in home medical services, hospitalization, required medication, nursing home care, etc. Examples include: conditions which are not accepted as normal for most functioning adults (common cold or mild depression vs. kidney disease or suicidal tendencies.) In most cases, the determination of the severity of injury / illness and a prognosis of the adult's medical / mental health status with, and without, the needed care will require confirmation by a physician or mental health professional, and this may require a referral to a DHS attorney to obtain an order for a physical or mental examination if the adult or caretaker cannot or will not consent.

2) **Inadequate food**

Self-neglect and neglect can include failure to receive food necessary to prevent physical injury or illness or to maintain life including failure to receive

appropriate food for persons with conditions requiring special diets ***(i.e., diabetics).*** It is important for the Intake Counselor to differentiate between the lack of appropriate nutrition as opposed to the caller's value bias regarding appropriate meals.

3) **Inadequate shelter**

- Inadequate shelter may consist of a structure which
  - is not structurally safe, or
  - Has rodent or other infestations which may result in serious health problems, or
  - May not have a safe and accessible water supply, heat source or sewage disposal, or
  - Has an environmental hazard that may result in serious health problems.

Note: Alleged victims do not necessarily require running water or central heat and air in their homes in order to be safe. Wood heat may be perfectly all right for one person but create a danger for another. An alleged victim who must rely on wood heat but is physically unable to chop or lift wood will have to have special arrangements made in order to ensure that they have heat when it is needed.

4) **Inadequate Clothing**

- Inadequate clothing can include lack of clothing considered necessary to protect a person's health or
- Clothing that is inappropriate for the weather and places the alleged victim at risk.

e. **Lack of Supervision**

- Requires total care (care that involves assistance with all ADLs and may require 24 hour supervision) and has been left without a caretaker, or wandering behavior that places the person at risk of harm, or
- Mental or physical disabling condition that interferes with person's ability to meet minimal needs and assistance is not available or is being withheld, placing the alleged victim at risk.

f. **Exploitation**

Tennessee law specifically defines exploitation as the improper use by a caretaker (defined above) of funds which have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult.

Referrals based only on exploitation are limited to the definition in the law. If the referral alleges the misuse of funds other than those paid by a governmental agency, then the allegations must also include one of the conditions listed under "abuse, sexual abuse, neglect, or self-neglect" in order for the protective service referral to be accepted. Protective Services would then be provided to alleviate the abuse or the neglect.

Note: Referrals based **only o**n the misuse of funds other than those paid by a governmental agency will not be accepted by APS for investigation but will be referred to law enforcement via the Form 1215.

g) **Emotional Abuse**

Emotional abuse is defined in the Adult Protection Act within abuse as

“The infliction of …. mental anguish…by a caretaker… . …..”

“Abuse or neglect” means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare. Nothing in this part shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment; further, nothing in this part shall be construed to require or authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the provisions of the Tennessee Right to Natural Death Act, compiled in title 32, chapter 11, and if the provisions of such medical care would conflict with the terms of such living will;

The Journal of Elder Abuse and Neglect, Vol. 10, April 1999, p. 120, defines psychological / emotional abuse as: *“the infliction of mental anguish or the provocation of fear, violence or isolation by a person in a relationship of trust. It diminishes the dignity, identity and self worth of the vulnerable adult.”*

Allegations of Patient to Patient / Resident to Resident Abuse

Referrals of incidents between residents / patients **will be accepted** when there is reason to believe, or it is alleged, that the facility administrator or staff (in their roles as caretakers):

- Were negligent,
- Failed to properly supervise the residents,
- Failed to take appropriate action to prevent the reported incidents from occurring,
- Could have anticipated an incident (*i.e.*, patient has a history of abusive acting out),
- The allegations include any form of sexual abuse, or
- The APS system indicates that there is an open case or that there have been other reports involving this victim or facility indicating negligence on the part of the facility.

It will be necessary for the intake counselor to question the reporter as to knowledge of prior incidents, as well as to check for previous APS reports and cases.

Referrals of incidents between residents / patients **will not be accepted, unless the allegation is sexual abuse** when:

- The incident reported is the first such incident involving either of the patients / residents (there is no pattern), unless severe abuse is alleged; or
- The referent has no reason to believe that the incident could have been anticipated by the facility, **and** the referent believes that the facility, as the caretaker, has responded appropriately to prevent additional incidents.

NOTE: Referrals of abuse, neglect and/or exploitation of patients / residents in facilities operated by the Tennessee Department of Mental Health or the Department of Intellectual and Developmental Disabilities (DIDD) **will not** be investigated by APS in accordance with T.C.A. 71-6-103(k). **Investigations of those allegations will be completed by investigators assigned to those agencies for that purpose.** This applies only to the following facilities:

Arlington Developmental Center
Clover Bottom Developmental Center

Greene Valley Developmental Center
Middle TN Mental Health Institute
Lakeshore Mental Health Institute
Western State Mental Health Institute
Memphis Mental Health Institute
Moccasin Bend Mental Health Institute
Group Homes established by DIDD that are state owned and state operated.

NOTE: Reports of harm to patients residing in one of the above facilities that occur while the adult is outside the facility **will** be accepted for investigation if it meets APS Criteria.

Exception: The relationship/role to the client in cases of sexual abuse.

Referrals Involving Death of an Alleged Victim - T.C.A. § 71-6-103(b)(1)

APS **may accept for investigation** referrals of a deceased alleged victim and may open a case in the name of the deceased alleged victim if there is reasonable cause to believe that abuse, neglect or exploitation occurred and contributed to the death of the alleged victim, the alleged perpetrator is a caretaker, and there is reason to believe other vulnerable adults may be at risk.

APS may open a case in the name of a deceased alleged victim who was residing in a facility prior to their death if there is reasonable cause to believe that abuse, neglect or exploitation occurred while the adult was in the care and supervision of the facility and those conditions contributed to the death of the alleged victim, the alleged perpetrator is a facility employee, and there is reason to believe that other vulnerable adults are at risk.

If a referral involves the death of an alleged victim reported to have died as the result of abuse or neglect, the information must be immediately conveyed by telephone to the investigative supervisor for the area in which the client resided. The referral must then be entered into the system and a Notice of Death must be created. The referral will be sent by the end of the business day to the investigative supervisor for the area in which the client formerly resided. The Notice of Death (NOD) will be sent by the automated system to the Program Supervisor.

NOTE: Law Enforcement must be contacted immediately by the Investigative Supervisor.

If another specific alleged victim is reported to be in similar circumstances, the referral as it relates to the alleged victim who is at risk will be accepted and a case will be established in that alleged victim's name.

Receiving a Referral Involving the Death of an Alleged Victim

- Intake will complete a referral and make a screening decision based on whether or not there is reasonable cause to believe that abuse, neglect or exploitation occurred and contributed to the death of the alleged victim, the alleged perpetrator is a caretaker**,** and there is reason to believe other vulnerable adults may be at risk.
- If the perpetrator was not a caretaker, and there is no reason to believe that other vulnerable adults are at risk, the referral may be screened out.
- Intake will notify the investigative supervisor who has responsibility for the area in which the deceased person resided, and the investigative supervisor or their designee will be responsible for reporting to licensure and/or law enforcement, including the TBI as appropriate, **immediately by phone or in person**. The notification will include APS' decision regarding investigation

Responsibilities Involved when Receiving Out of State Requests

Out of State Requests That Are Appropriate for APS Assignment

- An APS referral that meets the Tennessee criteria for investigation
- Requests for an interview or home study only, when requested through an APS agency in another state, will be processed as a referral and assigned to the county of the interviewee.

NOTE: If a referral is received that does not meet TN criteria (*i.e*., if it is for other than a collateral interview or home study), this referral should be screened out. For a collateral interview and home study, intake will mark the allegation received from the other APS agency to open the case in the automated system.

Out of State Requests That Are Inappropriate For APS Assignment

Non-referral requests that are not appropriate for APS assistance should be documented as an Information & Referral call.

- Callers requesting mental health services should be directed to TDMHDD.

NOTE: Interstate placement to and from mental health facilities are handled under the Interstate Compact on Mental Health and should be coordinated through the Tennessee Department of Mental Health and Department of Intellectual and Developmental Disabilities.

- Callers requesting services for an intellectual disability should be directed to the Regional Offices of Community Services and the Developmental Centers of Tennessee Department of Intellectual and Developmental Disabilities (DIDD).

Sensitive and High Profile Cases

There may be referrals that the Department becomes aware of that are considered sensitive or high profile due to the nature of the information pertaining to individuals in the referral. These referrals should be assigned with discretion and care.

Sensitive Referrals

A referral may be classified as sensitive at intake or at the investigation level.

The criteria for classifying a referral as sensitive includes:

- The referral pertains to an individual who is related to an APS employee
- The referral pertains to an individual who is an APS employee
- The referral pertains to an individual who has a conflict of interest with the investigator or with someone in the direct line of supervision. For example: a person employed in the office of the APS counselor, friend or acquaintance of an APS counselor, FS1, etc.

If a referral is classified as sensitive at the point of intake and that referral is assigned for investigation, then the investigation is also classified as sensitive.

When a referral is classified as sensitive, the intake counselor will contact the intake supervisor for a decision on assignment. The sensitive referral or investigation may need to be assigned out of the county or area. The intake supervisor will contact the program supervisor for assistance with assignment. If the referral involves a relative of an APS worker, it must be assigned outside the FS1's area. If the referral is on an APS employee, the referral must be assigned outside the program area. To assign a referral outside the alleged victim's county of residence, contact must be made with the supervisor in the receiving county to accept the referral.

High Profile Referral / Investigation

- This type of referral relates to a well-known public figure or a state employee in an executive management role.

- All referrals classified as high profile are automatically routed to the State Office staff. A state office person shall be responsible for assigning the referral to the appropriate APS Investigative staff.

- The General Counsel, Deputy General Counsel and Assistant Commissioner over APS in State Office are to be notified of all cases classified as high profile.

Note: The referral or investigation details on a Sensitive or High Profile case will not be visible on a person search in the automated system, unless you have appropriate security rights. A person without appropriate security rights will see a minimal amount of information that does not indicate the nature of the case.

Engaging the Referent

- APS intake staff will engage the referent in efforts to obtain pertinent information regarding the alleged victim's safety.

- Intake staff will provide general information to referents about the intake process and/or the investigative / assessment phase when requested by referents.

- Anonymous calls will be accepted but staff will encourage the referent, without pressuring them, to disclose their identity. It should be mentioned that any update on the investigation can not be provided unless the caller chooses to leave his/her name and number.

- If the caller continues to prefer anonymity, the caller's name and telephone number will not be recorded on the referral.

Information Given to the Referent

The intake worker may share all or part of the following information with the person making the referral, as considered appropriate:

- The law requires that referrals of abuse, neglect and/or exploitation be made.

- The law protects the referent from civil or criminal liability when making a referral in good faith even if the allegations are ultimately determined to be unfounded.

- If the referent calls back on a referral, asking to whom the case has been assigned, the intake counselor will provide the name and phone number of the investigative counselor and supervisor to whom the referral was assigned.

- The referent will be contacted by the investigative counselor, after the client's situation has been evaluated, to advise him / her as to whether or not the Department has decided to provide protective services.
- The law protects the confidentiality of the identity of the person making the referral unless we are required by court order to identify the referent.
- If the report is not appropriate for investigation, the intake person should share this information with the referent and explain why an investigation will not be initiated. Supervisory consultation should be obtained whenever necessary.
- Malicious and intentionally false reporting is a misdemeanor.

Information to be Obtained from the Reporter

The law lists specific information which the person making the report to APS is required to provide to the extent known:

- Name and address of the alleged victim;
- Age of the alleged victim;
- Name and address of the caretaker, if any;
- Nature and extent of the abuse, neglect or exploitation (including any evidence of previous abuse, neglect or exploitation);
- Identity and location of the alleged perpetrator, if known;
- Any other information that may be helpful in establishing the cause of the abuse, neglect or exploitation.

In addition, policy requires that the intake counselor obtain the following if possible:

- Is the alleged victim in danger at this moment?
- How is the alleged victim unable to protect him / herself from the alleged A/N/E?
- Directions to the home or alleged victim’s location.
- Overall description of the alleged victim.
- Does the alleged victim have any acute or chronic illness (es)?

- How does the alleged victim's medical condition(s) prevent self protection? Obtain specific information as to how it prevents self protection.
- Does the alleged victim have a diagnosed mental illness?
- How does any such mental illness prevent self protection? Obtain specific information as to how it prevents self protection.
- Does the alleged victim have any dementia, mental confusion, memory loss, Alzheimer's disease, etc.?
- How does the alleged victim's mental condition prevent self protection? Obtain specific information as to how it prevents self protection.
- Does the alleged victim exhibit any signs of frailty due to aging?
- How does the frailty due to aging prevent the alleged victim from self protection? Obtain specific information as to how it prevents self protection.
- Description of activities the alleged victim is able to do his / herself.
- Description of activities that the alleged victim cannot do for his / herself.
- Is there a primary caretaker? If so, who?
- Are there others involved in the alleged victim's life? If so, who, and in what capacity?
- Does the alleged victim have insurance? If so, who is the insurance provider?
- Does the alleged victim receive TennCare / Medicare?
- What is the source and amount of the alleged victim's income?
- What resources does the alleged victim have?
- Are there any services already being provided in the home? If so, what and by whom?
- Are there unusual or dangerous circumstances for which the counselor should be alert such as methamphetamine production or use, vicious dogs, weapons, etc.?
- Information for the intake staff to be able to determine if the alleged perpetrator is the caretaker. Do not ask if the alleged perpetrator is a caretaker as it is highly possible that the referent may not understand the Department's meaning of caretaker, so there will be many times when

Intake will make that determination based on the information received from the referent.

- Does the alleged victim have an advanced durable power of attorney for health care? If so, who is this person?
- Is a conservator responsible for the alleged victim's financial / medical status? If so, who is the conservator?

See Intake Practice Guide - Appendix A **for Cue Questions.**

Research of APS information

Information will be gathered regarding past history of the alleged victim's involvement with APS, as well as the past history of persons reported to be involved with the alleged victim to ensure that a comprehensive decision can be made regarding the vulnerable adult's safety and response priority. Research activities include a search of the APS system to capture any history of APS involvement.

Extended Intakes

There may be times when it is necessary for intake staff to gather information from someone other than the referral source in order to make an accurate screening decision. Contacts of this type should be resolved quickly so it can be assigned immediately if the referral is considered an A priority response. For all other priorities, the extended intake should be completed by the end of the next business day. If Intake is unable to gather additional information, screening decisions should be made based on available information. Attempts to gather additional information should also be recorded.

In those instances of extended intake, staff should document in the referral narrative:

- The individual who was called in order to obtain additional information;
- The date and time he / she was called;
- The address / phone / e-mail or other contact information;
- What factual information the individual provided; and
- All attempts to reach the individual.

Other calls made to APS Intake

Intake will accept and redirect calls to the appropriate entity when those calls are not related to APS referrals such as:

Information-only calls – Example: “Who is my worker?”
Questions about the county office address or directions, etc.

Intake will accept, document in the system, and redirect calls to the appropriate entity when those calls are not related to APS referrals such as:

Information and Referral (I & R) – Example: “Who do I call about….?” “My daughter is being beaten up by her husband.” “Who can I get to help her?”

“Who can help me with drawing up a will?” Etc.

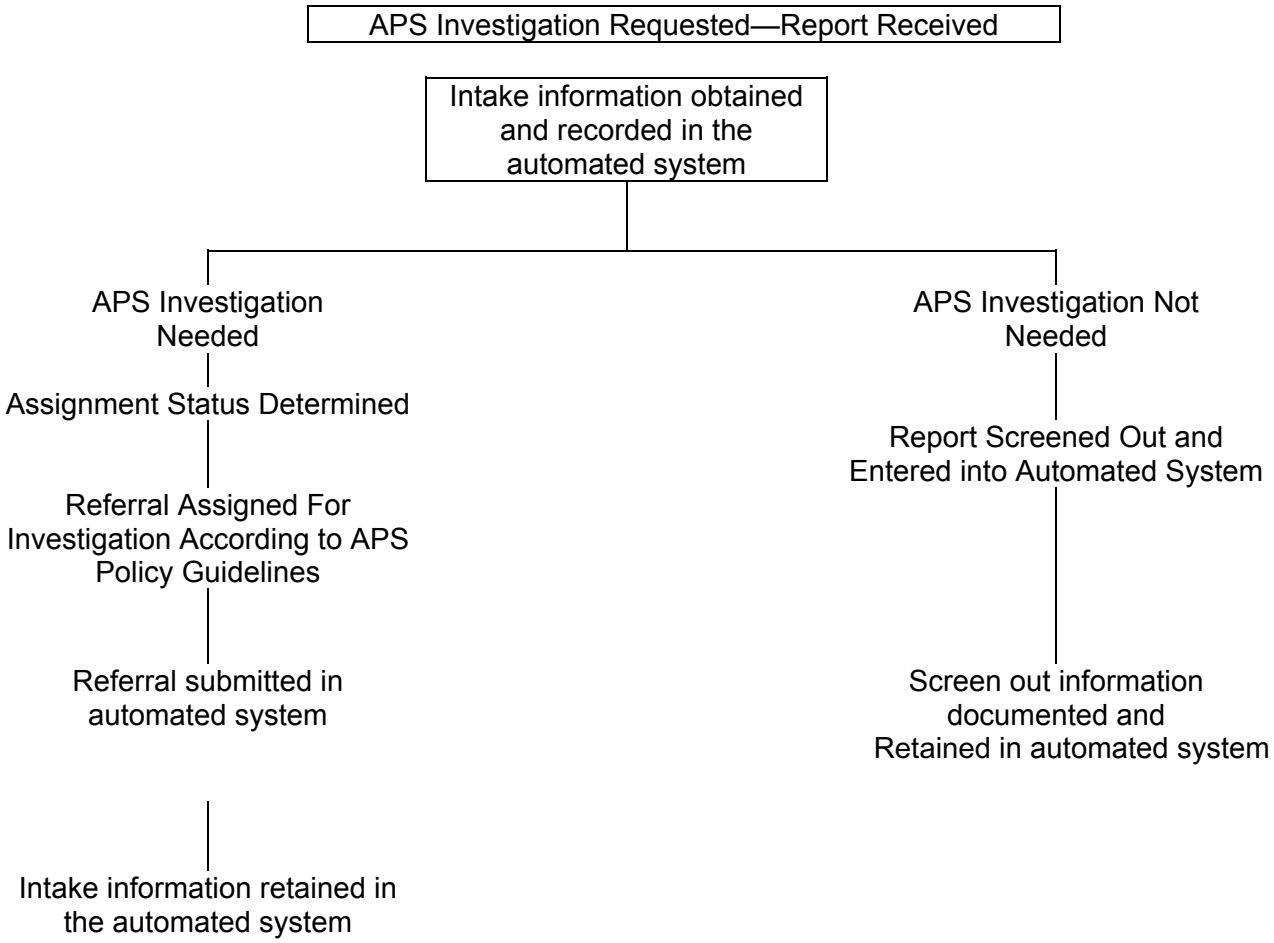
Reports of abuse and neglect occurring in other states will be referred to the appropriate NAPSA contact.

Intake will accept, document, and assign as appropriate courtesy requests (home study or interview) from other states.

In order to respond to requests of this type, the referent must be able to provide Intake with the name of an alleged victim, an alleged perpetrator, and an allegation that will be entered into the system.

The above information should be documented on the **intake form.**

FLOWCHART


APS Investigation Requested—Report Received
Intake information obtained and recorded in the automated system
APS Investigation Needed
APS Investigation Not Needed
Assignment Status Determined
Report Screened Out and Entered into Automated System
Referral Assigned For Investigation According to APS Policy Guidelines
Referral submitted in automated system
Screen out information documented and Retained in automated system
Intake information retained in the automated system

Chapter 5
SCREENING AND ASSIGNMENT POLICY

Legal Authority

T.C.A. 71-6-103(b)(1)

Purpose

To ensure referrals meet the criteria for APS assignment and appropriate information to make a screening decision is gathered in a timely and efficient manner.

Policy

Screening and Assignment

Intake staff will screen the referral to determine if the referral meets APS criteria for assignment, investigation and assessment. If the referral meets criteria, it will be assigned a response priority that determines the time frame for initiating the investigation. The referral will then be assigned to the appropriate APS Investigative Counselor or Investigative Supervisor (a referral with a Priority status of C may be deferred to the Priority Register by the Investigative Supervisor to whom it is assigned). If the referral does not meet criteria, it will not receive a priority status and will be screened out.

NOTE: **The fact that an individual has a disability does not imply that the referral should automatically be assigned. It is critical for intake to make a screening decision based on specific information as to how the disability impacts the alleged victim's ability to protect or provide for him / herself.**

The Intake Staff will:

- Screen each referral to determine the need for APS involvement;
- Assign a response priority; and
- Make the assignment to an appropriate Investigative Social Counselor / Supervisor.

All referrals will be assigned or screened out before the end of the business day on the day the referral is received, except for Priority Status "A" which must be done immediately upon receipt.

Exception: There may be times when it is necessary to gather additional information in order to make a screening decision, and this process is called extended intake. If a referral needing additional information is received, and it is

not an A priority status, intake may hold the referral until the end of the next working day while attempting to obtain additional information. If the referral is assigned an A priority status, the referral can only be held for extended intake for a short period of time as the referral must be assigned ASAP.

Referral Screen out

If the referral does not meet the criteria for assignment, the Intake Staff will:

- Select an allegation,
- Select a screen-out reason,
- Enter a screen-out narrative, and
- Submit their screening decision to the Intake supervisor for approval.

If the information received does not meet the criteria for assignment and investigation, the intake staff will select one of the following screen-out reasons:

- No allegation of physical abuse, neglect, or exploitation by a caretaker that meets criteria for assignment for an APS investigation;
- No physical or mental impairment or frailty due to aging that would prevent an alleged victim from protecting him / herself;
- Abuse / neglect / exploitation occurred in a facility operated by TDMH or DIDD;
- Referral does not contain enough identifying information to locate alleged victim;
- Duplicate referral;
- Information obtained as a referral is determined to meet criteria for I & R after a referral has been created;
- Alleged victim is under 18;
- Allegation of resident to resident or patient to patient abuse / neglect / exploitation does not meet criteria for APS investigation. Such an allegation will not meet APS criteria if the incident reported is the first such incident involving either of the patients / residents or facility, is not sexual abuse, the referent has no reason to believe that the incident could have been anticipated by the facility, and the referent believes that the facility, as the caretaker, has responded appropriately to prevent additional incidents.
- Deleted – Entered in error. This is security driven.

Procedure

- The Intake staff will document in the screen-out narrative why the referral did not meet criteria for assignment if additional explanation is needed.
- The screened-out referral will be forwarded to the Intake supervisor for approval.
- The Intake supervisor may approve the screen-out or return to the Intake counselor for additional work and/or assignment.
- After approval for screen-out, the Intake supervisor will forward the screened-out referral to the Investigative supervisor for approval.
- The Investigative supervisor may agree with the screen-out and approve, or may assign the referral by changing the disposition to “Assign” and setting the Priority Status.
- If the referral is approved and accepted as a screen-out by the Investigative supervisor, the Investigative supervisor or his / her designee will complete the 1215(s) and send to the appropriate agency(s).
- Screened-out referrals will be maintained in the automated system.
- A caller who reports conditions in a licensed / unlicensed health care facility and/or alleges violations of facility standards which are matters for the licensing agency but do not meet the criteria for APS investigation will be referred by APS intake to the TDH-HCF Centralized Intake Unit toll free number, 1-877-287-0010, M-F 7:00 a.m.-7:00 p.m.

Priority Response Options

Response priorities are assigned to referrals to determine the time frame in which an investigation / assessment must be initiated by the investigative social counselor.

A. **Priority A – Immediate Assignment and Response – A response must be initiated by midnight of the day the referral was assigned through face to face contact / interview either by the Social Counselor or law enforcement. If initiation is by law enforcement, the investigative counselor must follow up with face to face contact with the client within 2 working days of contact by law enforcement.**

		Category
1.	Physical abuse or neglect, by a caretaker, which has resulted in visible and/or serious injuries or has involved recent trauma to the head and/or body regardless of perpetrator's access to the reported alleged victim or any other vulnerable adult.	Abuse/ Neglect
2.	Unreasonable confinement, chemical restraints or any other factors that would indicate imminent danger to the vulnerable adult.	Abuse/ Neglect
3.	A caretaker is requesting immediate assistance from APS for fear he / she will harm the alleged victim.	Caretaker
4.	The alleged victim is threatening suicide and is alleging abuse / neglect / exploitation. **NOTE**: If the only issue is suicide, the referral should be referred to law enforcement and mobile crisis and screened out.	Mental Health
5.	There is reason to believe the alleged victim or caretaker is exhibiting psychotic, bizarre behavior including homicidal ideation involving the alleged victim which places the alleged victim in imminent danger.	Mental Health
6.	The alleged victim's judgment or physical condition is impaired to the extent that the alleged victim is in imminent danger.	Mental/ Physical Health
7.	The alleged victim needs total care and/or 24-hour supervision and has been left without a caretaker placing the alleged victim in imminent danger.	Neglect/ Caretaker
8.	There is reason to believe the caretaker may flee or move the alleged victim prior to the investigation or may move the alleged victim to an unknown location, placing the alleged victim in imminent danger.	Neglect/ Caretaker
9.	Neglect, by a caretaker, or self neglect, in which the alleged victim is without essentials for daily living (including immediate eviction) to the extent that the alleged victim is in imminent danger.	Neglect / Self Neglect/ Environment
10.	The alleged victim is in imminent danger and is unable to protect him / herself due to critical illness or a life threatening condition.	Physical Health
11.	There has been sudden deterioration in the alleged victim's condition making him / her unable to care for him / herself, placing the alleged victim in imminent danger.	Self Neglect

12.	Sexual abuse is alleged and the alleged perpetrator has ongoing contact with the alleged victim or other vulnerable adults.	Sexual Abuse
13.	Sexual abuse is alleged to have occurred within the past 72 hours.	Sexual Abuse
14.	The death of an adult that is reasonably believed to have been caused by abuse, neglect or exploitation, the alleged perpetrator is a paid caretaker and there is reason to believe other vulnerable adults may be at risk because the alleged perpetrator continues to have unrestricted access.	Neglect, Physical Abuse, Sexual Abuse, Environment
15.	The death of an adult in a facility that is reasonably believed to have been caused by abuse, neglect or exploitation perpetrated by facility employees, and there is a reason to believe that other vulnerable adults are at risk because the alleged perpetrator(s) continues to have unrestricted access.	Neglect, Physical Abuse, Sexual Abuse, Environment

B. Priority B – Immediate Assignment – A response must be initiated through face to face contact / interview with the alleged victim within 1 to 7 working days from the date of assignment, depending on emergent nature of allegations.

		Category
1.	Any factor that will result in serious harm to the alleged victim if services are not initiated within (7) seven days, such as repeated incidents, an established pattern of harm, medical treatment or services needed to reduce harm.	Abuse / Neglect
2.	An alleged perpetrator of abuse and/or neglect, who is a caretaker, does not currently have access to the alleged victim, but will have access within a short time frame.	Abuse / Perpetrator
3.	Stressed caretaker has self-reported or reported to others that continuing to care for the alleged victim may result in harm to the alleged victim.	Caretaker
4.	A caretaker has reported an illness or physical disability affecting the caretaker that is untreated or deteriorating to the point that supplementary services are needed to insure adequate care for the alleged victim and these services are not currently in place.	Caretaker

5.	The alleged victim is vulnerable and eviction is imminent. Official notice is given and the alleged victim has no other alternatives for housing.	Environment
6.	There is an environmental hazard or condition, such as a fire hazard, that places the alleged victim in danger.	Environment
7.	Financial exploitation, by a caretaker, that currently causes unmet critical needs or lack of care, placing the alleged victim at immediate risk.	Financial
8.	There is reason to believe the alleged victim or caretaker is exhibiting psychotic, bizarre behavior that places the alleged victim in immediate danger.	Mental Health
9.	Serious illness or non-visible injury that has been treated in the hospital and the alleged victim was subsequently released to a non-protective environment.	Neglect / Self Neglect
10.	Neglect or self-neglect of the alleged victim to the extent he / she is without needed services / resources to safely maintain independent living.	Neglect / Self Neglect
11.	Sexual abuse where the incident occurred beyond 72 hours, there are no visible injuries and the alleged perpetrator does not currently have access.	Sexual Abuse
12.	Sexual abuse is believed to have occurred within the past 72 hours, but the alleged perpetrator has no access to the alleged victim or other vulnerable adults, and a sexual assault exam has been conducted through law enforcement involvement.	Sexual Abuse

C. Priority C—Immediate Assignment to Supervisor – Supervisor may assign immediately to a social counselor or place on the priority register for future assignment depending on the availability of the investigative staff. Once assigned, a response must be initiated by the social counselor within 1-7 working days through face to face contact with the alleged victim.

		Category
1.	A stressed caretaker has reported that he / she is unable to continue to provide care for the alleged victim, they have exhausted available resources or there are none available, and the caretaker is requesting APS assistance.	Caretaker
2.	A stressed caretaker is consistently verbally abusive with some adverse psychological effects such as fear of others or depression and there is some concern that verbal behavior may later escalate to physical abuse.	Emotional Abuse / Caretaker

3.	The alleged victim is residing in a place where eviction is threatened and there are no plans for alternative housing.	Environment
4.	There are environmental conditions that are potentially unsafe, such as pest / rodent infestation, unsanitary, inoperable plumbing or no utilities, putting the alleged victim at risk.	Environment
5.	Financial exploitation by a caretaker that does not currently cause a lack of essential needs and/or care.	Financial
6.	The alleged victim's mental and/or physical condition or impaired judgment places him / her at some risk.	Mental Health
7.	There is reason to believe the alleged victim or caretaker is exhibiting psychotic or bizarre behavior that places the vulnerable adult at some risk.	Mental Health
8.	The alleged victim has minimal mental and/or physical disabling conditions and the allegations referred meet the minimal criteria for APS eligibility.	Mental/ Physical Health
9.	The alleged victim is receiving inconsistent or inadequate assistance with essential ADLs or lacks supervision, placing her / him at risk, but not in immediate danger.	Neglect/ Self Neglect
10.	Neglect by a caretaker or self neglect that puts the alleged victim in danger, BUT temporary services are being provided, although there is no long term plan in place.	Neglect/ Self Neglect
11.	The alleged victim has suffered physical abuse by a caretaker with no current injuries, and the alleged perpetrator is not currently believed to be present or have access to the alleged victim or any other vulnerable adults.	Physical Abuse
12.	An alleged victim is inconsistently meeting minimal needs for food, shelter, and/or essential ADLs.	Self Neglect
13.	A courtesy request from another state for a home study or an interview (should not be placed on the Priority Register).	

Referral Assignment

- Referrals will be assigned to the county of the alleged victim's primary residence unless it is a sensitive or high profile referral.
- A referral requesting a courtesy interview / home study from another state will be assigned to the county in which the subject of the referral resides.

- Any referral with a Priority Status of A that has not been accepted or reconsidered within 4 hours is automatically assigned for investigation by the system.

NOTE: Investigative Supervisors have 1 hour after receiving an A reconsideration to submit to the Intake Supervisor. Intake Supervisor has 1 hour to process reconsideration. If these time lines are missed the referral is automatically assigned by the system. Anything put in the reconsideration request is part of the permanent record.

- Any referral with a Priority Status of B or C that has not been accepted or reconsidered within 2 days is automatically assigned for investigation by the system.

A referral with an Assignment Priority Status of A will be assigned immediately. The intake counselor will complete search of APS history to determine if the alleged victim has had previous involvement with APS in any capacity. The Intake worker will determine by telephone or e-mail that an identified counselor is available to respond within appropriate time frames. If the counselor is not available, the supervisor is contacted. If the supervisor is not available, the program supervisor will be contacted. If the program supervisor is not available, the director or his/her designee will be contacted and a decision is made on the assignment. The intake worker changes the assignment as needed and documents the emergency handling narrative.

A referral with an Assignment Priority Status of B will be assigned immediately via the automated list for assignment to the county of the alleged victim's primary residence. The intake counselor will do a search to see if the client has had previous involvement with APS in any capacity.

An exception to this policy can occur if the Investigative Supervisor has indicated in the system that all Priority B referrals should come directly to him / her for assignment.

A referral with an Assignment Priority Status of C will be assigned immediately to the Investigative supervisor who has responsibility for the county of the alleged victim's primary residence. The Investigative Supervisor can either assign or defer to the priority register.

NOTE: Refer to Investigation Chapter. The intake counselor will do a search to see if the alleged victim has had previous involvement with APS in any capacity.

Reconsideration

Reconsideration is a request from the field staff for:

- A change in the referral assignment from assigned to screen-out;

- A change in the Priority Status to a lower Priority Status than what was given by Intake;
- Correction of information contained in the referral; and/or is not covered;
- Allegations not consistent with the narrative;
- Additional Information is needed.

NOTE: If the investigative supervisor determines it needs to be a higher priority, they can make the change without going through reconsideration on the automated system.

Reconsideration Guidelines

- Once the referral has been accepted for investigation, it cannot be reconsidered.
- Requests to intake for reconsideration of a referral may be made only 1 time during the life of the referral, prior to being accepted for investigation. The final decision rests with the APS director or his/her designee.
- In the automated system, if a referral with a Priority status of A is not reconsidered or accepted within 4 hours by the assigned worker**,** the referral is automatically designated as accepted for investigation. Each supervisor has only 1 hour to respond to the reconsideration request. If a supervisor does not respond to the request within 1 hour, the request is automatically rejected and assigned to the worker.
- If a Priority B or C referral is not reconsidered within 2 working days, the case is automatically designated as accepted for investigation.
- A Priority C referral that is deferred to the priority register can only be reconsidered **prior** to placement on the register.
- If a referral is received by an investigative social counselor who believes reconsideration should occur, the investigative counselor will contact his / her supervisor and discuss the referral and the request for reconsideration. The investigative social counselor should notify their supervisor before they are sent to them for reconsideration.
- If the investigative supervisor agrees that the referral should be reconsidered, he/she will **call** the Intake Supervisor to notify them that reconsideration is being sent. The referral will be returned to the Intake Supervisor. If the investigative supervisor disagrees with the investigative social counselor about the need for reconsideration, the reconsideration will be rejected and the referral will be automatically be accepted for investigation.

- Prior to returning the referral to intake, the investigative supervisor will document the reconsideration request, utilizing one of the reconsideration reasons (listed below) and recording the specifics in a reconsideration narrative field. **The reconsideration narrative will remain as part of the permanent record.**
- Upon receipt of the reconsideration, the intake supervisor will determine if the status is correct or the information in the referral is sufficient. If the intake supervisor agrees with the reconsideration request, the status or information in the referral will be changed by intake.
- If the intake supervisor and the investigative supervisor cannot reach an agreement, the referral will be referred to the APS director or his/her designee for the final decision.
- If a referral is screened out based on a reconsideration, the Investigative Supervisor shall contact the referent of the change in assignment.

Reconsideration Reasons

For a change in Priority Status A, B, or Defer C, options are:

- Field Requests Assignment
- Inaccurate Response Priority

For a Request for a Screen Out, options are:

- Duplicate Referral – When a referral is made by two referents on the same alleged victim or client with the exact same allegations, one referral will be screened out. (For example, the ER and ambulance service call on the same client regarding the same incident and same allegations.
- Reported allegations do not meet criteria for APS investigation.
- Allegations occurred in a facility operated by TDMH/DIDD.
- Allegations involve patient to patient or resident

For Intake Rework, options are:

- Additional information appears to be needed. It appears to the investigative staff that additional information is necessary to make an accurate screening decision. This may require an additional phone call to other individuals who may have knowledge of the situation or incident by

the intake counselor. This is not an investigative activity per se, but rather an “extended intake.”

- Allegations marked are not consistent with the narrative in the body of the referral. For example, the allegations describe neglect and financial exploitation only, but self neglect is also marked as an allegation.

- Correction of information contained in the referral.

NOTE: Program Supervisors are to be contacted for a change in assignment based on the need for reassignment due to conflict of interest and inaccurate county assignment. Intake will not make assignment changes; this is the responsibility of either the Program or Field Supervisor.

Chapter 6
INVESTIGATION POLICY

Legal Authority

Tenn. Code Ann. §§ 71-6-101 et seq.

Purpose

To investigate means to inquire into an allegation systematically and to examine it in detail. As information is gathered during the life of the case, it will be used to determine the truth of the allegations, determine who the perpetrator is, if possible / applicable, and will be used in conjunction with the risk factor matrix and safety assessment to determine the service needs of the client. Information gathered in the ongoing process of assessing the overall status of the client will be documented on the Safety Assessment and Outcome Measurement instrument and in case recordings. It may also be determined that the client does not need Protective Services, but they may wish to be referred for other available social services.

The purpose of the investigation is:

- To substantiate or unsubstantiate the allegations made concerning the client,
- To make a determination about the alleged perpetrator, unless self neglect is the only basis for the referral,
- To determine the extent of harm or danger to the client,
- To gather the information needed to assess the level of safety of the client, and
- To identify service needs and provide protective services for the client when necessary.

Policy

Upon receipt of a report of suspected abuse, neglect or exploitation, the Department is required to initiate an investigation of the complaint. To achieve the goal of reducing or eliminating the risks to the client, a thorough investigation is necessary. It is possible that the allegations may be unsubstantiated, but during the investigation, other protective service needs may be identified which must be addressed. Once the investigation is completed, the case will be closed or transferred to on-going services.

Self Determination

Clients, regardless of age or condition, have a right and responsibility to direct their own lives to the extent that it is possible for them to do so. This means that each client will:

- Be given every opportunity to make plans for him / her self to the degree possible.

- Be given as much information about the alternatives and options that are available to assist in making an informed decision. There may be differences between how the client perceives the problem and the APS assessment. While the client may be unwilling to accept the intervention which the Department identifies as providing the greatest safety for the client, he / she may be willing to accept alternative services which involve less intrusion on his / her personal freedom / autonomy but still reduce risk and enhance safety to some extent. In such situations, APS will accept the client's right to self-determination and provide those services which the client will accept. In no case should such a situation be viewed as a refusal of services.

Although the principle of self-determination requires that clients be free to make their own decisions, it is the responsibility of the Department to protect the client when the client's capacity for self-determination is impaired.

In providing protective service, there may be situations in which the Department will discuss with the client, family members, or authorized representative, a plan which the agency believes to be best for the client. If a client is resistant to or refuses all services, it is required that the Social Counselor attempt to encourage acceptance by using diligent efforts.

Reasonable effort should be made to help the client accept services, if services are needed. If a client who is refusing protective services knows his / her options, is able to recognize the problem, understands and accepts the consequences of refusing services, and APS has made an effort to help him / her accept services, then his / her right to self-determination will be respected. If an adult with capacity refuses services already in place, after reasonable efforts as indicated above, the services will be withdrawn. If the client refuses services and does not appear to have the capacity to make such a decision, then legal intervention will be considered.

Exception: Mental Health - Suicidal Client – A client who appears to understand that his / her decisions may result in death may still need to be evaluated by a mental health professional if there are reasons to question his / her mental status. The APS staff should contact their supervisor for consultation as to whether or not to contact Law Enforcement or Mobile Crisis.

Lack of Capacity- Practice Guide - Appendix B

Undue influence occurs when people use their role and power to exploit the trust, dependency, and fear of others (Singer, 1996; Quinn, 2001). Exploiters use this power to deceptively gain control over the decision making of their victim (Singer, 1996). Undue influence is a pattern of manipulative behaviors that enable an exploiter to get a victim to do what the exploiter wants, even when the victim's behaviors are contrary to his or her previous beliefs, wishes and actions. These tactics are similar to those used by cults and hostage takers and in brainwashing.

Problems or severe problems in any of the following areas may indicate a lack of capacity to consent to services. These signs indicate a need for further assessment to determine capacity. While the list is not exhaustive, one or a combination of problems in the following areas suggest a need for further investigation / assessment to determine capacity:

- Disorientation – inability to tell date, time, location or event;
- Disordered thought processes – paranoia, delusions, inability to answer questions coherently;
- Inappropriate affect – unprovoked angry outbursts, unexplained laughter or tearfulness, depression / withdrawal from others;
- Bizarre behavior – constant movement, repetitive actions, verbal or physical aggression;
- Memory disturbances – inability to recall recent events or accurately report a recent newsworthy story;
- Mental illness that is untreated with medication(s) – symptoms not well controlled;
- Alcohol or substance abuse by the client – chronic abuse, evidence of intoxication during the interview;
- Inability to understand problems or medical conditions and consequences of failure to receive treatment for those conditions– denial of problems or consequences of untreated medical conditions, failure to recognize problems or develop plans for dealing with them;
- Failure to report or resist abuse, exploitation or neglect by others;
- Hoarding;
- Uncontrolled hazards in the home – many animals, serious pest or rodent infestation, large quantities of garbage, substantial clutter that seriously impairs use of the home;

- Malnourishment;
- Financial mismanagement resulting in serious financial problems;
- Very poor personal hygiene; and/or
- Thoughts of suicide, homicide or self-injury.

Any sign that a client has trouble recognizing problems, developing plans to address those problems or difficulty carrying out the identified plans should be taken as an indication of possible incapacity. When a client in crises or vulnerable status accepts services, appropriate actions should be taken in a timely manner.

The counselor should consult with the supervisor about possible legal intervention when a client is in crisis or vulnerable status, accepts services, but:

- Appears to have diminished decision-making capacity; and
- Does not have a support system sufficient to keep the client safe.

Initiation of Investigation

- **Priority A** – Requires initiation of an investigation through a face to face interview with the client by APS Staff or Law Enforcement on the same day the referral is assigned. (See Special Circumstance regarding utilizing Law Enforcement.) If Law Enforcement is utilized for the initial contact, APS staff shall have follow up contact with the Law Enforcement entity that responded and have a face to face contact and interview with the client within 2 working days.
- **Priority B** – Requires initiation of an investigation through a face to face interview with the client by APS Staff within 1-7 working days of assignment.
- **Priority C** – Requires initiation of an investigation through a face to face interview with the client by APS Staff within 1-7 working days of assignment, unless the referral was deferred to the Priority Register by the FSI. In that case, the initiation time frame is 1-7 days from the date of assignment off the priority register.

Special Provision in Emergency Situations—Use of Law Enforcement

This provision is limited to special situations involving priority status A referrals. Under these conditions the supervisor may approve a request from the assigned APS Counselor to ask law enforcement in the client's county to check on the client's condition and safety. The following must exist:

- The call was received after hours; or
- The only way to ensure that a client in alleged dangerous circumstances is seen immediately is to ask local law enforcement to do a "welfare check"; or
- Multiple reports requiring immediate response are received on the same day; and
- Neither the assigned Counselor nor their supervisor is able to respond to all the emergency reports on a timely basis; and
- Counselors in contiguous counties are unable to respond to the emergency reports.

NOTE: If law enforcement is utilized in an emergency situation, the social counselor is required to follow up with face to face contact with the client within 2 working days.

Good Faith Attempt to Meet Response Times for Initiation of the Investigation

There must be a good faith attempt to meet those response times described above, and all good faith attempts to initiate the investigation within time frames must be documented as case recordings. If time frames for initiating the investigation are not met, the counselor must complete the “Diligent Efforts” checklist and scan into automated system, along with any completed investigative tasks, to the Investigative Supervisor for approval.

“Good faith attempts” or “diligent efforts” are defined as those persistent, relevant attempts to meet the policy time frames for initiation of an investigation.

If the APS staff learns, upon proceeding to the location given, that the address does not exist, the address is incorrect, or the client is not at the location, the following activities, as applicable, constitute a “good faith attempt”:

- Making 2 or more visits to the client’s reported location during different times of the day during the timeframe for initiation.
- Interviewing neighbors who might have information as to the location of the client.
- Calling the referent to verify reported information and to attempt to obtain additional information.
- Checking with the post office and utility companies to obtain information on the client.

- Calling other individuals, as appropriate, listed on the referral to obtain information on the client.
- Contacting any known relatives.
- Contacting local, county and state law enforcement agencies to check their records for information about the client.
- Researching previous APS records.
- Researching local directories for address information.
- Contacting the landlord, if applicable.
- Sending a certified letter to the client.
- Conferring with the supervisor to determine the next course of action.

If staff is denied access to the client by the caretaker, client or other individuals, the legal authority to see the client will be explained to those individuals. (Legal Section - Chapter 11) If access is still denied, the APS Staff will:

- Immediately contact the supervisor for assistance;
- Contact law enforcement for assistance;
- Perform activities defined as diligent efforts to engage the client or caretaker who is resistant to the investigation;
- If necessary to obtain access, Legal will be consulted for a search warrant.
- Document all attempts in the case recording.

Diligent Efforts to Engage Client or Caretaker who is Resistant to the Investigation

NOTE: An investigation cannot be refused by either the caretaker or the alleged victim. Discuss all attempts to refuse the investigation with TDHS Legal.

- Make a minimum of one face-to-face visit with the client or caretaker after refusal.
- If one face-to-face visit is not possible or reasonable, document why.
- Make contacts to obtain information about the client's situation and possible risks.
- Contact the referent regarding the refusal if appropriate.
- Document in case recordings the attempts to engage the client in conversation on topics that would help develop a relationship.

- Enlist the help of family, friends, or professionals to engage the client in accepting the need for the investigation. Document if there is no one available to assist.
- Evaluate if the referral or other information gathered suggests a need for Legal intervention and consult with Legal as appropriate.
- Consult with supervisor about the refusal or resistance to the investigation.

Gaining Entrance into a Client's Home

APS law requires a visit to the address where the client resides. Many clients reside in their home or the home of others. While a visit is required, it is important to be aware that APS cannot enter a home uninvited except under very specific circumstances. Entering a home uninvited not only is a violation of an individual's privacy, but could result in criminal trespass charges being filed against the Social Counselor. If there is a "no trespassing sign," contact Legal for guidance and document the response in case recordings.

APS staff shall:

- Ensure they are invited into the client's or other's home;
- Not enter a home when the occupants are not at home;
- Contact Legal for possible search warrant if they are unable to gain entrance to a home;
- Contact Law Enforcement if there is a reasonable cause to believe that a client is in immediate danger at the time of the visit and they are unable to gain entrance into the home.

Guidelines for Completing Investigations Involving Different Allegations (Non-facility)

<u>Self Neglect</u>

Required

- Face to face contact / interview / observation with the client alone.
- Home Visit and/or visit to current living arrangement if applicable.
- Research prior APS records if prior records exist.
- Collateral Contacts including but not limited to:
    - all formal service providers;
    - referent

- all relevant people who have been determined likely to have critical information about the current allegations for risk of harm; and witnesses.

- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:

  - APS has completed its investigation and will continue to be involved, providing on-going services; or

  - APS has completed its investigation and will be closing its case; or

  - Services were offered and refused and case is being closed.

- Safety Assessment and Outcome Measurement.

- Refer for services if appropriate. Service Provision Policy - Chapter 10 and Practice Guide - Appendix F

- Verification of type of health insurance, TennCare/Medicaid, etc.

- Notification of animal cruelty to local animal shelter – when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

- Obtain medical / mental health records or obtain information from medical / mental health professionals who are believed to have information about the client.

- Review client's financial records / information.

- Take photographs/video of the client and the client's circumstances if relevant to the allegations unless taking the photographs or video substantially impedes the investigation by agitating the client or if directly told to stop by the client who appears to have capacity, or if told to leave.

Physical Abuse

Required

- 1215 notification to law enforcement and licensing agency.
- Face to face contact / interview / observation with the client alone.
- Interview the alleged perpetrator if a paid caretaker
- Home Visit and/or visit to current living arrangement if applicable.

- Take photographs of the alleged victim if there are visible injuries and the client's circumstances if relevant to the allegations unless taking the photographs or video substantially impedes the investigation by agitating the client or if directly told to stop by the client who appears to have capacity, or if told to leave.

- Research prior APS records, if prior records exist, including a check of the Vulnerable Person's Registry if the alleged perpetrator is a paid caretaker.

- Collateral Contacts including but not limited to:

    - all formal service providers,

    - referent

    - all relevant people who have been determined likely to have critical information about the current allegations for risk of harm, and witnesses.

- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:

    - APS has completed its investigation and will continue to be involved, providing on-going services; or

    - APS has completed its investigation and will be closing its case; or

    - Services were offered and refused and case is being closed.

- Safety Assessment and Outcome Measurement.

- Refer for services if appropriate. Service Provision Policy - Chapter 10 and Practice Guide - Appendix F

- Verification of type of health insurance, TennCare/Medicaid, etc.

- Notification of animal cruelty to local animal shelter, when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

- Interview alleged perpetrator.

NOTE: If the alleged perpetrator is a paid caretaker, this is not optional.

- Obtain medical / mental health records, including photographs, or obtain information from medical / mental health professionals who are believed to have information about the client.

- Complete body diagram or obtain medical documentation / evaluation if there are visible injuries.
- Check the Vulnerable Person's Registry.

Sexual Abuse

Required

- Notify law enforcement by phone if sexual assault occurred within 72 hours of receipt of referral.
- 1215 notification to law enforcement and licensing agency.
- Face to face contact / interview / observation with the client alone.
- Interview the alleged perpetrator if a paid caretaker.
- Home visit and/or visit to current living arrangement if applicable.
- Research prior APS records if prior records exist including a check of the Vulnerable Person's Registry if the alleged perpetrator is a paid caretaker.
- Collateral Contacts including but not limited to:
    - all formal service providers
    - referent
    - all relevant people who have been determined likely to have critical information about the current allegations for risk of harm, and witnesses.
- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:
    - APS has completed its investigation and will continue to be involved, providing on-going services;
    - APS has completed its investigation and will be closing its case; or
    - Services were offered and refused and case is being closed.
- Safety Assessment and Outcome Measurement.
- Refer for services if appropriate. Service Provision - Policy Chapter 10 and Practice Guide - Appendix F
- Verification of type of health insurance, TennCare/Medicaid, etc.
- Notification of animal cruelty to local animal shelter – when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

- Interview alleged perpetrator.

NOTE: If the alleged perpetrator is a paid caretaker, this is not optional.

- Obtain medical / mental health records or obtain information from medical / mental health professionals who are believed to have information about the client.
- Obtain a sexual assault medical evaluation if within 72 hours.
- Check the Vulnerable Person's Registry

Financial Exploitation

Required

- 1215 notification to law enforcement and licensing agency.
- Face to face contact / interview observation with the client alone.
- Interview the alleged perpetrator if a paid caretaker.
- Home visit and/or visit to current living arrangement if applicable.
- Obtain copies of financial information and identify the location of institutions where the client's assets may be located.
- Determine if the client has either an "attorney-in-fact", i.e., a person with a power of attorney (POA) or a conservator with authority over the client's finances or other person in a fiduciary capacity such as a trustee from whom the client receives funds.
- Research prior APS records if prior records exist including a check of the Vulnerable Person's Registry if the alleged perpetrator is a paid caretaker.
- Collateral Contacts including but not limited to:
    - all formal service providers,
    - referent
    - all relevant people who have been determined likely to have critical information about the current allegations for risk of harm, and witnesses.
- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:

- APS has completed its investigation and will continue to be involved, providing on-going services;
- APS has completed its investigation and will be closing its case; or
- Services were offered and refused and case is being closed.

- Safety Assessment and Outcome Measurement.
- Refer for services if appropriate. Service Provision Policy - Chapter 10 and Practice Guide - Appendix F
- Verification of type of health insurance, TennCare/Medicaid, etc.
- Notification of animal cruelty to local animal shelter – when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

Interview alleged perpetrator.

- **NOTE**: If the alleged perpetrator is a paid caretaker, this is not optional.
  - Obtain medical / mental health records or obtain information from medical / mental health professionals who are believed to have information about the client.
  - Check the Vulnerable Person's Registry.

Neglect by Caretaker

Required

- 1215 notification to law enforcement and licensing agency.
- Face to face contact / interview / observation with the client alone.
- Interview the alleged perpetrator if paid caretaker
- Home visit and/or visit to current living arrangement if applicable.
- Research prior APS records if prior records exist including a check of the Vulnerable Person's Registry if the alleged perpetrator is a paid caretaker.
- Collateral Contacts including but not limited to:
  - all formal service providers,
  - referent

- all relevant people who have been determined likely to have critical information about the current allegations for risk of harm, and witnesses.

- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:
  - APS has completed its investigation and will continue to be involved, providing on-going services;
  - APS has completed its investigation and will be closing its case; or
  - Services were offered and refused and case is being closed.
- Safety Assessment and Outcome Measurement.
- Refer for services if appropriate. Service Provision Policy - Chapter 10 and Practice Guide - Appendix F
- Verification of type of health insurance, TennCare/Medicaid, etc.
- Notification of animal cruelty to local animal shelter – when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

- Interview alleged perpetrator.

NOTE: If the alleged perpetrator is a paid caretaker, this is not optional.

- Obtain medical / mental health records or obtain information from medical / mental health professionals who are believed to have information about the client.
- Take photographs/video of the client and the client's circumstances if relevant to the allegations unless taking the photographs or video substantially impedes the investigation by agitating the client or he caretaker or if directly told to stop by the client who appears to have capacity or by the caretaker, or if told to leave.
- Check the Vulnerable Person's Registry.

Emotional Abuse

Required

- 1215 notification to law enforcement and licensing agency.
- Face to face contact / interview / observation with the client alone.

- Interview the alleged perpetrator if a paid caretaker
- Home Visit and/or visit to current living arrangement if applicable.
- Research prior APS records if prior records exist including a check of the Vulnerable Person's Registry if the alleged perpetrator is a paid caretaker.
- Collateral Contacts including but not limited to:
    - all formal service providers,
    - referent
    - all relevant people who have been determined likely to have critical information about the current allegations for risk of harm, and witnesses
- Notification to referent, unless anonymous, of the outcome of the APS investigation. The referent will be told:
    - APS has completed its investigation and will continue to be involved, providing on-going services;
    - APS has completed its investigation and will be closing its case; or
    - Services were offered and refused and case is being closed.
- Safety Assessment and Outcome Measurement
- Refer for services if appropriate. Service Provision Policy - Chapter 10 and Practice Guide - Appendix F
- Verification of type of health insurance, TennCare/Medicaid, etc.
- Notification of animal cruelty to local animal shelter – when applicable.

Recommended: If actions are not taken / completed, the APS staff will document reasons why in the case recording.

- Interview alleged perpetrator.

NOTE: If the alleged perpetrator is a paid caretaker, this is not optional.

- Obtain medical / mental health records or obtain information from medical / mental health professionals who are believed to have information about the client.
- Obtain mental health evaluation if needed.
- Check the Vulnerable Person's Registry.

Institution / Facility Investigations

Guidelines for Completing an Investigation in a Facility or in an Environment in which there is a Paid Caretaker who is the Alleged Perpetrator.

Residents of institutions / facilities who are believed to be abused, neglected and/or exploited are to be reported to TDHS the same as adults who live in private residences.

Exception: The Tennessee Department of Human Services shall not be required to investigate, and the Tennessee Department of Mental Health (TDMH) / and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD), as well as group homes that are state-owned and state-staffed by DIDD, shall not be required to report to DHS any allegations of abuse, neglect or exploitation involving its residents that occur within any institutions operated by TDMH or DIDD. Allegations occurring in such institutions shall be investigated by investigators of TDMH or DIDD. Go to Intake - Chapter 4 for a list of those facilities.

However, allegations of any incidents which involve residents of such institutions but occur outside the premises of the institution's facilities, or that occur in community residences licensed by TDMH or DIDD or in facilities licensed by another authority, shall be reported to and investigated by TDHS / APS**.** In a case in which APS conducts an investigation in a facility or requires access to persons or information in a facility, APS will generally be dealing with the administrator of the facility.

All guidelines listed above by allegation apply when completing an investigation of a client who resides in an institution or a facility. In addition to the guidelines above, the following additional steps / measures are also required:

- Send a 1215 directed to the TBI if conditions warrant and the facility is the recipient of Medicaid funds.
- Send the 1215 to local law enforcement.
- Send a 1215 to Health Related Boards as appropriate.
- Send a 1215 to licensing agency.
- Review / obtain copies of care plans.
- Review / obtain copies of chart notes.

- Review / obtain copies of mental and/or physical health records of client(s).
- Review / obtain copies of employee work schedules (if employee is alleged to be the perpetrator or the perpetrator is unknown).
- Review / obtain copies of personnel records and personnel history.
- Observe the location of the alleged incident.
- Take photographs/video of relevant physical locations
- Interview any facility staff alone, not in the presence of a third party, such as a union representative, friend, supervisor or other staff employed by the facility.
- Interview alleged perpetrator.
- Review / obtain copies of doctor orders and/or nurse notes.
- Review / obtain copies of incident report.
- Review / obtain copies of any written witness statements, perpetrator interviews, or other employee interviews.
- Review / obtain copies of facility investigation reports.
- Notify licensing agency if any health or safety hazards are noted.
- Review / obtain copies of social work assessment and progress record.
- Check the Vulnerable Person's Registry

Recommended obtaining the following, if applicable:

- Blood chemistry report,
- Patient weight record,
- Monthly nursing assessment,
- Hospital transfer orders,
- Physician's progress notes,
- Police records,
- Physician's telephone orders,
- Special labs, and
- Pertinent training materials.

Tennessee Department of Mental Health (TDMH)

Allegations of abuse, neglect or exploitation of a facility resident which allegedly occur while the resident is outside the facility will be investigated by APS the same as allegations regarding adults in private residences. In the course of the investigation,

APS staff will have the authority to enter a TDMH facility to have access to the client and to any other persons or records in the facility which are needed to conduct the investigation.

TDMH investigators and APS staff are encouraged to conduct investigations jointly if it is appropriate. This will be determined on a case-by-case basis. When conducting joint investigations, each agency will share relevant information.

All interventions available to the APS program through services or legal action will be used as appropriate in cases in which abuse / neglect / exploitation occurred while the resident was in the care and control of an individual who is not a staff member of the facility and the incident occurred off-site.

Tennessee Department of Intellectual and Developmental Disabilities (DIDD)

Allegations of abuse, neglect or exploitation of a facility resident which allegedly occur while the resident is outside the facility will be investigated by APS the same as allegations regarding adults in private residences. In the course of the investigation, APS staff will have the authority to enter a DIDD facility to have access to the client and to any other persons or records in the facility which are needed to conduct the investigation.

DIDD investigators and APS staff are encouraged to conduct investigations jointly if at all possible.

All interventions available to the APS program through services or legal action will be used as appropriate in cases in which abuse / neglect / exploitation occurred while the resident was in the care and control of an individual who is not a staff member of the facility and the incident occurred off-site.

Tennessee Department of Health (TDOH)

The Tennessee Adult Protection Act mandates that the Department of Human Services provide protection to residents of licensed and unlicensed health care facilities just as it mandates protection for adults in other living arrangements.

APS staff are encouraged to coordinate investigations with the Tennessee Department of Health / Health Care Facility (TDOH / HCF) when possible,

including scheduling of interviews, etc. However, the APS investigation will be initiated within response time frames required by APS policy.

Licensed Health Care Facilities

The Tennessee Department of Health has the legal responsibility to license facilities which provide varying levels of health care services. These include:

- Hospitals,
- Nursing Homes,
- Assisted Living Facilities,
- Homes for the Aged.

Responsibilities of APS Staff Regarding Investigating Referrals in Health Care Facilities

- Notify the HCF Licensing on Form 1215 (HS-0875) or
- Notify HCF Licensing immediately of referrals which allege physical or sexual abuse or life threatening neglect of a resident in a licensed or unlicensed health care facility.
- Report referrals received after hours on the **next working day** to the appropriate regional office.
- Notify HCF Licensing of any event in which a **licensed facility** does not report allegations of abuse, neglect and/or exploitation of an adult in its care **in a timely manner as required by state law**. Notification may made by telephone, but will be followed by a brief written notification to the appropriate HCF regional office that includes:
    - The name of the facility;
    - The name of the alleged victim;
    - The date on which the incident became known to the facility;
    - The date on which the report was made to APS;
    - A brief statement of the type of alleged maltreatment.
- APS will refer to the TDOH / HCF Centralized Complaint Intake Unit at 1-877-287-0010 (M-F, 7:00 a.m.—7:00 p.m.) complaints alleging conditions which do not warrant an APS investigation. This includes any conditions the counselor may encounter in the facility at any point in the investigation that raise concerns about the conditions or general quality of care being

provided in the facility. Notification may occur by telephone or by use of the 1215.

Special Considerations for Investigations in Unlicensed Facilities

The investigative process is essentially the same for APS in both licensed and unlicensed health care facilities except for the following considerations:

- HCF staff has no authority to enter the premises of an unlicensed facility, as it is essentially private property. Therefore, APS staff will recognize that HCF cannot enter an unlicensed facility, either with APS staff or independently.
- The HCF surveyor must have the permission of the provider to enter the premises.
- HCF will not be conducting an investigation in the unlicensed facility. In all other matters of collaboration / sharing information, the relationship between APS and HCF is the same.
- TBI will need to advise APS staff regarding the TBI's authority to enter the unlicensed facility in question.

Joint or Independent Investigations with Any Agency [TDMH, DIDD, TBI, Local law enforcement, TDOH HCF]

There will be occasions when APS staff and investigators from other agencies will be involved in investigating a referral of allegations regarding the same victim. In those instances, the preferred method of investigation would be for all agencies to investigate jointly. However, due to time frame requirements of other agencies, it may be necessary for APS to conduct an independent investigation.

Required Activities for APS in Joint / Independent Investigations

In instances where there are multiple agencies involved in the same investigation, there may be certain activities that could be delegated to the other agency. However, in those instances, it is critical that the information be shared with APS in order for the staff to be able to complete an assessment and the investigation. It is APS' responsibility to ensure that vulnerable adults are protected, so the type of information gathered by the other agency is critical to achieve that goal.

There are activities that APS staff must conduct as required by law or policy and they are as follows:

- Face to face interview with the client,
- Home or site visit,
- Sending the 1215,
- Assuring the safety of the client,
- Meeting required time frames,
- Completing a Safety Assessment and Outcome Measurement,
- Obtaining a copy of the investigative report from the other agency and reviewing the investigative report to ensure that all APS concerns were addressed,
- Documenting the investigation including the agreement with the investigative party,
- Entering all information in the case file,
- Classifying the investigation/case.

Guidelines for Investigating Deaths Alleged to be the Result of Abuse / Neglect or Exploitation by a Caretaker or Unknown Perpetrator

There may be situations where a referral is received and assigned for investigation on a deceased adult. In order for APS to accept the referral for investigation, it must contain reasonable cause to believe that the death is due to abuse / neglect / exploitation, and the alleged perpetrator must be a paid caretaker or an unknown perpetrator who has access to other vulnerable adults in a facility or through on-going care.

In addition, APS may have an open investigation / case on a client when the client dies due to apparent abuse / neglect / exploitation by a paid caretaker or an unknown perpetrator that has access to other vulnerable adults.

In both instances the APS investigative staff shall:

- Immediately notify law enforcement and /or TBI (as appropriate) and the appropriate licensing agencies;
- Develop a plan with law enforcement / TBI and the licensing agency regarding an investigative plan and the activities that each entity will conduct;
- Document all activities;

- Obtain a report from a coroner or doctor about the death;
- Classify the investigation / case;
- Complete Notice of Death;
- Consider Special Review if appropriate; and
- If activities are delegated, see Joint / Independent Investigations for guidelines.

NOTE: When investigating these types of cases APS staff are not required to conduct a face to face contact or a Safety Assessment / Outcome measurement.

Investigative Tasks to be Completed for Investigating Deaths

There are certain activities that are critical when investigating the death of a vulnerable adult. It is important to obtain as much information as possible in order to protect other vulnerable adults who may have contact with the alleged perpetrator.

The responsibility of APS is to protect vulnerable adults who may be in danger. While it is not the role of APS to prosecute, it is important for APS to have operating agreements with law enforcement regarding investigations of cases involving death. While there will be times when it is more appropriate for law enforcement to take the lead in an investigation, APS cannot allow endangerment of other individuals who might be at risk. APS should continue investigating the allegations to ensure other individuals are not at risk while law enforcement is investigating the alleged criminal act.

The following activities are required, but may be completed by law enforcement. Information from interviews performed by law enforcement should be obtained and recorded in the APS record.

- Interviewing other vulnerable adults for whom the caretaker was responsible;
- Interviewing witnesses;
- Interviewing collaterals;
- Interviewing the alleged perpetrator;
- Visiting the facility, if the death did not occur in the home; and
- Photographing the site.

Priority Register

All referrals that meet the criteria for APS investigation will be accepted and investigated. They will be assigned for investigation according to the alleged

level of risk to the client, a process of triage that allocates staff resources first to those at greatest risk at times when resources may be limited.

Priority Register Policy

- Investigative supervisor will submit the 1215 if deferred by the supervisor to the priority register or designate the 1215 task to a social counselor.
- Investigative supervisor will contact the referent to notify of placement of the referral on the priority register and will document.
- Every 30 days, the investigative supervisor will contact the referent and document that contact.
- If the referent is anonymous, the investigative supervisors will, as appropriate, contact other individuals listed in the referral and document information. If not appropriate, then documentation will be entered stating the referral was anonymous.
- The investigative supervisor will update the computer system with assignment information once a counselor is assigned.
- An investigative supervisor may assign a referral to a social counselor off the priority register at any point regardless of the intake date.
- A referral may remain on the priority register for a maximum of 9 months. At the end of 9 months, the referral must either be assigned or closed without investigation.
- A case may be closed from the priority register if the situation which placed the client at risk is resolved, and the client is no longer at risk.
- If additional information is received that changes the allegations and results in the referral meeting the criteria for a different assignment status, the investigative supervisor will assign a response status and assign the referral to an investigative counselor.
- Once assigned from the priority register, the date of assignment of the referral is the date it was assigned to the investigative counselor, and the time frame for initiation of the investigation begins with the date the referral is assigned to the investigative counselor.

Placement of a Name of an Indicated Perpetrator on the Vulnerable Person's Registry

During the course of an investigation, there may be situations where the APS staff has the necessary evidence and proper authority to place the name of an indicated perpetrator on the Vulnerable Person's Registry which is administered by the Tennessee Department of Health. The names and other information

contained in that registry are available for public inspection after completion of applicable due process procedures.

Prior to contacting the Department of Health for placement of the name, the following guidelines must be met:

- A thorough APS investigation was conducted and has been concluded.
- The case was found to be valid, and there is sufficient information to indicate a specific paid caretaker of specific maltreatment (A/N/E) of a vulnerable adult.
- The indicated perpetrator has received the appropriate and necessary due process. Chapter 20 - Due Process Requirements**.**

Conclusion of Investigations

Once an investigation is complete, there are certain activities that must be in place in order to conclude or end an investigation. At the point of concluding an investigation, the Social Counselor will either close the case or transfer to on-going services.

APS staff shall formally complete all investigative tasks, case recordings, and Safety Assessments within 60 days of the assignment date of the referral to the Social Counselor.

There are required investigative tasks which must be completed and documented in the automated system and reviewed by the supervisor. They are:

- Investigation Initiation - Successful or Unsuccessful - For Unsuccessful, see Closed Without Investigation
- Client face to face meeting - Successful or Unsuccessful - For Unsuccessful, Link to Closed without Investigation Chapter 13 - Unless the referral involves the death of the client.
- Client in home meeting – Documented
- Client interviewed alone – Documented
- Insurance - Documented
- Perpetrator Interview – Documented. If not, document why not.
- Pre-Safety Assessment and Outcome Measurement tool – Documented – Unless the referral involves the death of the client.

- Post Safety Assessment and Outcome Measurement tool documented for cases transitioning to on-going services;
- Collateral Contacts - Documented
- Closure Safety Assessment and Outcome Measurement tool documented for cases that will be closed, both investigations and on-going services;
- Case Recordings to document the following:
    - Dates of contacts,
    - Types of contacts,
    - Names of persons contacted and relationships to the client,
    - Issues discussed and client's responses;
- All documentation gathered, e.g., medical information reports from service providers, signed releases, photos, etc.;
- Copies of all completed 1215s;
- Documentation that the client was notified of the outcome of the investigation;
- Notification of the referent, unless anonymous, that the investigation is complete and whether or not APS will continue to be involved with the client;
- Disposition of all allegations;
- Determination all perpetrators;
- Classification of the case as valid / invalid / valid threat of harm.

NOTE: For transition of a case to on-going services, the classification of the case must be either valid or valid threat of harm;

- "Diligent Efforts" documented if the case is valid, but the client refuses services or if the client refuses to cooperate with the investigation; and
- Decision for either case closure or on-going services documented in the investigation summary and based on the safety level of the client.
- All legal documents that may have been utilized as part of the investigation

Extensions for Incomplete Investigations at 60 days

There may be situations when, due to circumstances beyond his / her control, an APS staff person may be unable to complete an investigation within the 60-day time frame.

These instances may be appropriate when APS staff is:

- Unable to locate individuals who are critical to the outcome of the investigation;
- Involved in a joint investigation and the other agency is unable to complete their part of the investigation in 60 days; and/or
- Investigating a case that is extremely complex and requires additional time to complete a thorough and accurate investigation.

In those instances, the following steps will occur:

- The Social Counselor will discuss the situation with his / her FS1 or Program Supervisor in the absence of the FS1 and obtain approval for a 30 day extension;
- The FS1 will document the reason for the delay and the plan for completion;
- If the investigation is not completed within the 30 day extension, the FS1 will discuss the case with the Program Supervisor; and
- If approved for an additional 30 days, the Program Supervisor or State Office Staff in the absence of the Program Supervisor will document the reason for the delay and plan for completion.

Extensions of investigations are not appropriate due to:

- Absences of APS staff or
- Staff inability to complete investigations for other than the reasons stated above.

Photography/Video

The purpose of photographs and video is to document an injury or lack of alleged injury; the physical condition of the client; incident scenes; and living environments. It is important to take photographs and/or video in every case where a client has, or is alleged to have, injuries that may have been caused by abuse or neglect. Photographs and/or video should also be taken of living

environments that constitute a health or safety hazard to the client, especially when going to court is a possibility.

When possible, APS staff should also take photographs and/or video to document:

- Any type of physical evidence (for example: a belt that was used to hit the client; the client's bed that is torn and soiled; or large holes in the client's floor); and
- Extensive cleaning and/or repairing of client's home or yard (before and after photographs).

Accountability Requirements and the Rights of the Client

Accuracy and Accountability

In documenting the existence or nonexistence of injuries, the Social Counselor should take all photographs as soon as possible. Since bruises or other marks on the body may not be visible immediately, it is equally important for the Social Counselor to follow up 24 to 48 hours after the initial face-to-face contact to determine if additional photographs are needed to accurately document the injury.

The Social Counselor should begin the photography documentation process by taking at least one establishing photograph that shows the client's face and the injury, or absence of the alleged injury, in the same frame, to the extent possible. The Social Counselor should then take at least one close-up of every injury or alleged injury. The Social Counselor or client should hold a ruler or an object of well-known size against the injury to show its size.

The Client's Right to Refuse Photography

In general, photographs of client's injuries should be taken even if this requires the client to remove clothing or display areas considered private. Clients have the right, however, to refuse to be photographed or to have their homes photographed. If a client does refuse, the Social Counselor should explain that photographs are important evidence and that they may be useful in protecting the client and providing services. Such discussions should not be pressed to the point of jeopardizing the client's cooperation with the investigation. If the client continues to refuse, do not take the photos.

Documentation of Refusal by Client to Be Photographed

When a client refuses to be photographed or to allow their property to be photographed, the Social Counselor should document the refusal in the case

narrative. If photographs are deemed essential to the investigation, contact the FS1 and seek legal assistance.

Procedures for Sensitive Photography

When taking photographs of body areas considered private, the Social Counselor must:

- Be of the same gender as the client; and
- Have a witness present.
- If the conditions cannot be met, consult with their supervisor for direction.

Photographing Living Environments

The Social Counselor shall begin with a photograph of the entryway to the dwelling or room when documenting living environments. The Social Counselor will then take a series of photos in a clockwise sequence from the center of the area or from a corner.

Documenting the Use of Photographs

To properly document the use of photographs, the Social Counselor:

- Identifies the individual in the photograph;
- Records in the case recordings that photographs of a client's injuries, home, repairs, and so on, were taken and by whom; and
- Lists and records, in case recordings, a description of each photograph taken.
- Ensure that each photograph is electronically time and date stamped.

Tape Recorded Interviews

Tape recorded interviews can often enhance an investigation. It is important to note that tape recording an interview with a client may be intimidating to the client and should be carefully considered. However, there may be times when it is important to accurately capture the interview of an alleged perpetrator, especially if the individual is a paid caretaker and may require due process. If the individual refuses to participate in a taped interview, APS staff must take thorough and accurate notes. In tape recording an interview, APS staff must, on the recording:

- Identify the date and beginning time of the interview;
- Identify themselves for the record;

- Ask each individual present in the room to identify themselves; and
- Identify the time the interview was concluded.

Chapter 7
INVESTIGATION CLASSIFICATION POLICY

Purpose

To ensure that all APS investigations are properly classified, the Social Counselor must organize, analyze, and weigh the investigation information to derive a classification for the investigation. The classification process is multi-tiered. The Social Counselor must determine, based on the assessment and evidence gathered, the disposition of the allegation, the perpetrator determination, the classification of the investigation and the need for continued APS intervention.

Legal Basis and Policy—Standards of Evidence for Investigation and Classification of Allegations

The standard of proof for purposes of determining if the allegation is substantiated or unsubstantiated and for the provision of protective services to that client with the client's consent is "**substantial and materia**l **evidence**."

"Substantial and material evidence" – The standard for indicating an allegation of abuse, neglect or exploitation and maintaining an open case in order to provide protective services. Substantial and material evidence is relevant evidence that furnishes a reasonably sound factual basis for the decision. This means that there is enough credible evidence regarding whether an event has occurred or a factual situation exists that the decision makes sense when looked at objectively and it is reasonable to act upon that evidence. It is a lesser level, or standard, of evidence than the "preponderance of evidence" or "beyond a reasonable doubt" standards of evidence discussed below and should not be the basis for deciding to initiate legal action or to indicate a perpetrator or abuse, neglect or exploitation for placement on the Vulnerable Persons Registry.

"**Preponderance of the evidence"** – The standard of proof required for indicating a perpetrator and/or for considering legal intervention on behalf of a client. This standard means that the greater weight of the evidence demonstrates that it is more likely than not that something has occurred. This may be analogized from a quantitative standpoint, for example, by demonstrating credible evidence from the investigation that supports a finding that it is 50.1% more likely that something occurred versus a level of evidence of 49.9% that it did not occur.

The evaluation of whether the evidence meets this standard will ultimately be made by the Department's attorney for the case, but, in determining if a case is ready to submit for a legal referral for legal action on behalf of the client, or to indicate A/N/E by a perpetrator against the client, the evidence that is gathered

must be of such quantity and quality that it will meet this standard in order to initiate legal action by the Department.

"Beyond a reasonable doubt" – The evidentiary standard that is required for a criminal conviction. The State must prove that –

- Each element of the criminal offense happened; and
- That the crime was committed by the defendant.

This does not mean that the State must prove that the defendant committed the offense "beyond all doubt", or "beyond a shadow of a doubt," only that he / she is guilty beyond a "reasonable" doubt. If called upon to testify in a criminal case involving the abuse of a client, any evidence provided by the Department's staff will be used to reach this standard of proof.

Determination of an Investigation

The Social Counselor disposes of an allegation, determines the status of an alleged perpetrator, and classifies a case based on all evidence gathered during the investigation. Each allegation must be separately addressed, and the basis for indicating each alleged perpetrator must be analyzed in relation to the allegation.

This determination is a multi-step process where the Social Counselor must do the following:

- Address and dispose of allegation(s) as substantiated or unsubstantiated
- Determine the alleged perpetrator(s) as indicated, unfounded, unable to determine or unknown. Exception: the allegation of self neglect has no perpetrator
- Classify the case as:
    - Valid as to the existence of A/N/E
    - Valid threat of harm due to A/N/E
    - Incomplete or
    - Invalid

NOTE: The classification will be derived by the automated system.

The explanation of each step is described below:

Disposition of Allegation:

Substantiated - Determination that the information gathered during the investigation supports that A/N/E or self neglect occurred. This disposition is based on substantial and material evidence that the allegation did occur.

Unsubstantiated - Determination that the information gathered during the investigation does not support that A/N/E or self neglect occurred.

Determination of Perpetrator:

Perpetrator Indicated - To indicate the alleged perpetrator, there must first be a substantiated allegation of A/N/E. Credible evidence (facts) of one or more of the factors in paragraph 2, "Factors", below, or other credible evidence, **that meets the standard of "preponderance of the evidence,"** may be used to substantiate that:

- A/N/E of a client has occurred; and
- **That a particular individual is responsible for the A/N/E involving that client.**

Factors: The following factors represent some of the bases for determining if A/N/E exists, and that a particular person is responsible for the A/N/E suffered by the client. These are not exhaustive, and other types of evidence from other sources can, and should, be considered in making the determination of A/N/E and the indication of a perpetrator:

- Medical and/or psychological information from a licensed physician, medical center, or other treatment professional, that substantiates that physical abuse, neglect, sexual abuse, or severe physical abuse occurred. This substantiation may be that the injuries are not consistent with a credible explanation of the cause of the injuries or that the injuries are non-accidental;
- Audit, bank records or other similar evidence of the financial circumstances of the client which are indicative of financial exploitation by the alleged perpetrator;
- An admission of A/N/E against the client by the perpetrator;
- The factual statement(s) of a credible witness or witnesses that support that the client was the subject of the abusive or neglectful act or indicate other witnesses who have knowledge of the facts involving the incident;

- The client victim's statement, that is credible and consistent, that the abuse or neglect occurred, supported by additional information obtained during the investigation;
- A determination that the alleged incident / situation is feasible relative to time and place;
- Physiological indicators or signs of abuse or neglect, including, but not limited to, cuts, bruises, burns, broken bones or medically diagnosed physical conditions;
- Physical evidence that could impact the substantiation of the allegation and the determination of the perpetrator;
- The existence of behavioral patterns that may be indicative of abuse / neglect and which suggest that other evidence of abuse or neglect should be examined;
- Supporting documentation, such as written statements, medical reports, law enforcement reports, incident reports, photographs, logs, work schedules, etc.;
- The existence of circumstantial evidence linking the alleged perpetrator to the abusive or neglectful act(s) (e.g., client was in care of the alleged perpetrator at the time the abuse occurred and no other reasonable explanation of the cause of the abuse exists in the record or from the APS investigation);
- The alleged victim exhibits new or changed behaviors that support the occurrence of the incident / situation;
- The allegation(s) conforms to the statutory definition of the report type, or;
- Other evidence that supports the existence of A/N/E and, if applicable, that this occurred due to the acts or omissions of another person.

Perpetrator Unfounded

The indication of an alleged perpetrator is unfounded when the information gathered in an investigation cannot substantiate by a preponderance of the evidence that the person named as the alleged perpetrator committed the alleged acts, even if A/N/E of the client is substantiated.

Perpetrator Unknown

The perpetrator is unknown if sufficient information does not exist to identify a perpetrator or if no specific individual is alleged to be the perpetrator.

Unable to Determine Perpetrator

An alleged perpetrator is named; however, there is not enough information to either indicate the alleged perpetrator by a preponderance of the evidence or to disprove the allegations against the alleged perpetrator.

Classification of Investigation Results:

The classification of the results of an investigation is derived from the disposition of the allegation. Below are the classifications and determinations that determine the disposition of the investigation.

Valid: Allegations of A/N/E upon which the investigation was based are determined to be "valid."

- If the factors described above, or other credible evidence, demonstrate "substantial and material" evidence of the occurrence of A/N/E, this permits the provision of protective services to the client with the client's consent; or

- If the allegations of A/N/E meet the "preponderance of evidence standard" that A/N/E has occurred, and, if applicable, that a particular person or persons committed A/N/E against the client, then protective services can be provided without the client's consent by way of a court order obtained by the Department's legal staff and, if applicable, a perpetrator can be indicated.

Invalid: Allegations upon which the investigation was based are determined to be "invalid," *i.e.*, there are no substantiated allegations of A/N/E and the assessment does not indicate that there is any threat of harm. Under this classification, no indication of a person as perpetrator can be made.

Valid Threat of Harm: There has been no substantiation of allegations that A/N/E or self neglect has occurred but, without intervention, there is a substantial probability that harm will occur to the client in the immediate or foreseeable future. With a finding of "Valid Threat of Harm," the client is at risk for A/N/E or self neglect (even if no injuries are currently present). The factors on the assessment reveal the impending abuse, neglect, exploitation or self neglect. Under this classification, however, no legal action can be taken to obtain legal authority to take the client into custody or provide other protective services without the client's consent and no indication of a person as a perpetrator of A/N/E can be made.

Incomplete: The investigation is unable to be completed. Under this classification, no legal action can be taken to obtain legal authority to take the client into custody or provide other protective services without the client's consent and no indication of a person as perpetrator of A/N/E can be made.

Chapter 8
SAFETY ASSESSMENT/OUTCOME MEASUREMENT POLICY

Legal Authority

T.C.A. 71-6-103(d) (4)

Purpose

The Safety Assessment / Outcome Measurement process provides a mechanism and tool that assists the APS staff in identifying relevant safety information, strengths and underlying needs of APS clients. The information gathered and evaluated in the Safety Assessment / Outcome Measurement tool will assist the APS staff in making decisions about the safety of clients, measure improvements and outcomes, insure the development of service plans when warranted, and facilitate appropriate service provision.

Policy

Safety Assessment and Outcome Measurement is a process by which the Social Counselor evaluates, on a continual basis, the safety of the client and the outcomes to the client based on APS intervention. The Safety Assessment / Outcome Measurement instrument (HS-2971) is a tool by which information gathered during that process is recorded and evaluated. The Safety Assessment / Outcome Measurement instrument shall be completed on **every** case unless the case is closed without investigation. The HS-2971 will be completed using the information obtained during the investigation. The assessment process enables the counselor to review all information obtained and make decisions regarding the need for services. The HS-2971 may be completed multiple times during the life of a case.

When to Complete an Assessment

Pre-Safety Assessment / Outcome Measurement shall be completed:

- On all new referrals
- On new referrals received on cases that are open for ongoing service provision
- When the APS staff have gathered enough information to create an accurate “snapshot” of the client at the time the investigation was initiated
- Prior to closing an investigation unless the case is approved to be “closed without investigation”

- Within 60 days or less of the assignment of the referral

Closure Assessment / Outcome Measurement shall be completed:

- Upon closure of an investigation and no later than 60 days from the receipt of the referral

- Upon closure of an on-going services case

Post-Ongoing Assessment / Outcome Measurement shall be completed:

- Upon completion of the investigation of any case left open for ongoing service provision

Periodic Safety Assessment / Outcome Measurement shall be completed:

- Six (6) months after the date of the Post-Safety Assessment / Outcome Measurement in a case open for service provision

- Every 6 months thereafter for the life of the case open for service provision

Periodic-Safety Assessment / Outcome Measurement (Assessment Sheet and Assessment Scale) is recommended any time there is a significant change in the client's situation

Elements of the Safety Assessment / Outcome Measurement

For each Safety Assessment / Outcome Measurement instrument completed, the following domains must be evaluated:

- Environment
- Financial
- Physical Health
- Mental Health
- Substance Abuse
- Developmental Disabilities
- Activities of Daily Living (ADL's)
- Informal Supports
- Formal Agency Supports
- Caretaker
- Elements of Abuse / Neglect

The risk factor matrix-link to practice guide Appendix D should be used as a guide in conjunction with the domains of the safety assessment to more accurately determine whether the client's level of safety is crisis, vulnerable, stable, or thriving.

Assessment of the Client's Condition and Circumstances

Completion of the Safety Assessment / Outcome Measurement instrument will:

- Identify what information is known to the counselor,
- Identify the level of safety for each aspect evaluated,
- Evaluate each aspect of the adult's circumstances and condition independently of the others,
- Determine the levels of safety of the client,
- Determine the strengths of the client,
- Calculate an overall score reflecting the client's current circumstances,
- Assist in determining a need for services,
- Allow the APS staff to measure outcomes when completed after an investigation that included provision of services,
- Allow the APS staff to measure outcomes at appropriate intervals in a case in which there is ongoing service provision.

Chapter 9
ON-GOING SERVICES POLICY

Legal Authority

71-6-101, 71-6-103 (g)

Purpose

At the conclusion of the APS investigation and completion of the Pre and Post Safety Assessment, it may be determined that the client remains at risk of harm and would benefit from further involvement by APS. This means that the client has "the need for ongoing services." Prior to providing on-going services, all allegations must be disposed of, all alleged perpetrators must be determined (unless a case of self-neglect), the investigation must be completed and approved, and the investigation classification must be valid or valid threat of harm. The automated system will auto-generate an action plan based on those domains determined to be at a level of crisis or vulnerable derived from the Post Safety Assessment.

Policy

Action Plan

An action plan is required on any APS case which remains open for ongoing services. The action plan documents the need for protective services after the investigation. The purpose of the service action plan is to provide direction to efforts to alleviate or reduce identified problems or risks by specifying actions to be taken and resources to be utilized. The plan must:

- Be developed with the client to the extent possible;
- Address the critical issues that place the client at risk;
- Include informal service providers in the development to the extent possible;
- Include presenting problems that are ranked as **crisis** or **vulnerable**;
- Describe the plan for action;
- Describe the desired outcome;
- Identify target dates for referrals for services;
- Identify names of service providers; and

- Be revised as needed throughout the life of the case, no less than every 6 months.

Periodic Safety Assessment and Outcome Measurement

Periodic Safety Assessment and Outcome Measurements will reflect the progress and/or changes in the case and whether or not services being provided are effective and continue to be needed.

Periodic-Safety Assessments:

- Shall be completed six (6) months from the date of the completion of the investigation and transition to on-going services;
- Shall be completed every six (6) months thereafter throughout the life of the case;
- May be completed at any time prior to six (6) months if a major change in client circumstances occurs in the case;
- Shall address the critical issues identified and any significant changes;
- Shall identify any new issues that place the client at risk of harm; and
- Shall document the need for continued APS intervention or case closure.

Contact with the client

A minimum of one (1) face-to-face visit per calendar month is required as long as the case is open. Some clients may need more than one contact a month, depending on their circumstances.

During the visits, the Social Counselor shall:

- Evaluate the appropriateness of the services being provided;
- Evaluate the effectiveness of the services being provided;
- Determine the reduction of risk to the client;
- Identify any new risks, problems or needs and document accordingly; and
- Plan and focus on the safety of the client.

Information obtained during the visits must be documented in case recordings.

Additional Monthly Contacts

It is important to gather information from others who are actively involved in the client's life while ongoing services are provided. Contacts with others must be:

- Made regularly, as appropriate, with anyone who, while not a provider of services, may have knowledge of the client and the client's circumstances;
- Made regularly, as appropriate, with any informal service provider to obtain information regarding the client's progress; and
- Made regularly, as appropriate, with any formal service provider to obtain information regarding client's progress. If several services are obtained from one provider agency, contact need only be made with the supervisor of the various individuals actually providing the services.

Information obtained from these contacts must be documented in the case recordings.

Self Determination

Clients, regardless of age or condition, have a right and responsibility to direct their own lives to the extent that it is possible for them to do so. This means that each client will:

- Be given every opportunity to make plans for himself / herself to the degree possible;
- Be given full and honest information about the alternatives and options that are available to assist in making an informed decision;
- Be given the opportunity to direct the degree and order in which services are provided; and
- Be protected through APS intervention when the client's capacity for self-determination is impaired.

If a client has the capacity to understand and make decisions and is in need of relocation but refuses relocation despite the counselor's best efforts, then APS will continue to provide whatever services the client will accept in his / her current environment that will improve the client's level of safety.

In providing protective service, there may be differences between how the client perceives the problem and the APS safety assessment. Accordingly, situations may arise in which the client, or others involved with the client, objects to a plan which the agency believes to be best for the client and will provide the greatest level of safety. In such situations, it is the responsibility of the Social Counselor to encourage acceptance by using diligent efforts. By doing so, the client may ultimately agree to the plan or at least some level of services which reduce risk and enhance safety at least to some extent. In such situations, APS will accept the client's right to self-determination and provide those services to which the client will agree. **In no event should such a situation be viewed as a refusal of services.**

Any sign that a client has trouble recognizing problems, developing plans to address them, or carrying them out should be taken as an indication of possible lack of capacity. Supervisory consultation to determine the most appropriate way to proceed in the case is recommended.

Although the principle of self-determination requires that clients be free to make their own decisions, it is the responsibility of the Department to protect the client when capacity for self-determination is impaired.

Diligent Efforts to Engage

There may be times when APS is working with a client to alleviate risks, and the client becomes resistant and refuses all services. When this occurs, the Social Counselor should attempt to stay involved and engaged with the client and make reasonable efforts to help the client appreciate the need for protective services. In those instances, the Social Counselor shall:

- Make at least one more face-to-face visit with the client and/or caretaker after the refusal or document why the visit was not possible.
- Enlist the help of family, friends or professionals, if available, to engage the client in accepting services.
- Determine if the client recognizes that a problem exists and understands the severity of the problem.
- Determine if the client sees other options to address the current situation.
- Determine if the client knows the consequences of failing to deal with the problem.
- Determine if the client's circumstances reflect a need for legal intervention and pursue if needed.
- Consult with the supervisor about the refusal of services.
- Document efforts to determine if the client recognizes the severity of the existing problems.

All activities related to diligent efforts must be documented on the checklist and scanned into the automated system.

Reasonable efforts should be made to help the client accept services. If a client who is refusing protective services understands the options available, is able to recognize the problem, and understands and accepts the consequences of refusing services, then the right to self-determination should be respected after

APS has made an effort to help them accept services. Services will be withdrawn. If the client refuses services and does not appear to have the capacity to make such a decision, then legal intervention will be considered.

Exception: Mental Health - **Suicidal Client**

A client who has a questionable mental health status and appears to understand that decisions that are made may result in premature death should be encouraged to obtain an evaluation by a mental health professional

Possible Indicators of Lack of Capacity

Problems of any severity in any of the following areas may indicate a lack of capacity to consent to services:

- Disorientation – inability to tell date, time, location or event
- Disordered or confused thought processes – paranoia, delusions, inability to answer questions coherently
- Inappropriate affect – unprovoked angry outbursts, unexplained laughter or tearfulness, depression, withdrawal from others
- Bizarre behavior – constant movement, repetitive actions, verbal or physical aggression
- Memory disturbances – short term memory loss (for example the inability to recall recent events or accurately report a recent newsworthy story)
- Mental illness that is untreated – symptoms not well controlled
- Alcohol or substance abuse by the client – chronic abuse, evidence of intoxication during the interview
- Inability to understand problems – denial of problems, failure to recognize problems or develop plans for dealing with them
- Failure to report or resist abuse, exploitation or neglect by others
- Hoarding
- Uncontrolled hazards in the home – many animals, pest or rodent infestation, large quantities of garbage, substantial clutter that seriously impairs use of the home
- Malnourishment
- Financial mismanagement resulting in serious financial problems

- Very poor personal hygiene
- Thoughts of suicide, homicide or self-injury

The list above is not exhaustive. Any sign that a client has trouble recognizing problems, developing plans to address those problems or difficulty carrying out the identified plans should be taken as an indication of possible incapacity.

When a client at crisis or vulnerable status level accepts services, appropriate actions to implement services should be taken in a timely manner.

The counselor should consult with the supervisor about possible legal intervention when a client is at crisis or vulnerable status level, accepts some services, but:

- Services accepted and provided do not significantly improve the level of safety;
- The client appears to have diminished decision-making capacity; and
- The client does not have a support system sufficient to keep the client safe.

Chapter 10
SERVICE PROVISION POLICY

Legal Authority

T.C.A. §§ 71-6-103, T.C.A. 71-6-107(b); 71-6-109; 111 and 112; 71-6-113

Purpose

If the Department determines that a client is in need of protective services, it shall provide or arrange for the provision of the appropriate services except in cases in which the client chooses to refuse such services.

Consent of the client may be given in various ways ranging from outright acceptance to reluctant acceptance with much reservation and misgiving. In the latter situation, efforts to provide needed service should continue unless the adult makes a definite decision to withdraw consent. If a client refuses needed services, diligent efforts must be made to facilitate acceptance of needed services by the client. On-going Services Policy Chapter 9-Diligent Efforts

Services, both formal and informal, may be provided during the investigation, as well as throughout the life of a case kept open for ongoing services. Legal action is only used in severe cases as a last resort, but will be considered a service and will be entered on the action plan in the automated system.

Policy

APS provides services to those clients who accept services. If there are circumstances in which the client refuses to accept needed services, other options, including legal intervention, must be explored. It is important to note that each service serves a different role and will be appropriate depending on the circumstances of the case. It is the Social Counselor's and Supervisor's decision to determine the services that will meet the needs of the clients.

Service Options

When attempting to identify appropriate services for a client, it is important to think about location, accessibility, availability, funding etc. **The initial Face-to-Face contact with the client must have occurred prior to deciding to provide services**. Practice Guide - Appendix F

APS Counselor's Actions and Activities

During the course of an investigation, or at any time throughout the life of an APS case, actions taken by the APS counselor in an effort to reduce or eliminate identified risks may be considered as an informal service (*i.e.*, efforts to persuade

a client to accept services, working with a client to develop a safety plan, giving a client information about resources).

SAFETY PLANS

Clients who are assessed as living in dangerous circumstances in which abuse / neglect / exploitation or self neglect has occurred or is likely to occur can be helped in several ways. One of those ways is to develop a safety plan with the client. The APS staff should determine the client's willingness to make changes and expected outcomes. Some ideas for the safety plan, if the client consents could be:

- Removing alleged perpetrator if the allegation is abuse or neglect
- Removing client from the situation that involves A/N/E or self neglect
- Helping to develop a written plan between the client and alleged perpetrator
- Helping the client to identify someone to contact in an emergency
- Assisting the client with putting together an “escape” bag
- Assisting the client with organizing his / her belongings and identifying which things are most important if the client is forced to leave suddenly

Some clients who are capable of making a decision regarding a living arrangement may decide to maintain the relationship with the perpetrator or continue to engage in self neglecting behaviors. In these cases the role of the APS Counselor is to support and encourage the client to take action(s) which will reduce the risks to him / her. Practice Guide - Appendix F

Adult Day Care

Adult day care may be an option to assist with alleviating neglect, abuse or self neglecting behaviors. This option will provide activities and supervision for the client provided outside the home for part of the 24-hour day.

Adult day care provides:

- programs for adults who need some level of supervision throughout the day
- programs for adults who have physical, neurological or emotional problems requiring special intervention or care
- an opportunity for socialization

- activities that help cognitively or physically-challenged adults maintain or improve their levels of functioning
- respite for family members
- services that delay institutionalization as long as possible

An Adult Day Care provider is a private agency which is licensed by TDHS, Adult and Child Care Licensing Division. There are three (3) avenues by which this service can be accessed:

- Private pay only
- Private pay supplemented by Social Services Block Grant (SSBG) funds Practice Guide - Appendix F
- CHOICES program Practice Guide - Appendix F

Counseling

This could be any one of several types of counseling, *i.e.*, mental health counseling, financial counseling, marital counseling, caretaker stress counseling, etc.

Interpreters / Translators for the Deaf / Hard of Hearing

When an interpreter for the deaf or hard of hearing is needed to complete the APS investigation and/or assist with providing services, APS staff shall:

- Notify the supervisor and document the communication in the case file.
- Refer to and select a service provider from the list provided by the Tennessee Registry of Interpreters for the Deaf. http://www.tennessee.gov/humanserv/rehab/cics.pdf
- Submit to TDHS Fiscal an original invoice, completed Authorization to Vendor Form for processing and payment with a cover letter referencing the communication about the need for interpreter services, and verification that the services were completed.
- Maintain copies of all documentation in the automated system.

Teletype Writer (TTY)

There may be occasions when it is appropriate to use TTY services instead of an individual interpreter. There is no charge for the service in Tennessee other than

customary telephone charges. The number is 1-800-848-0299.
Practice Guide - Appendix F

Interpreters for Language Barriers

APS staffs have access to translation services for communication with individuals who have limited proficiency in the English language. This service is provided by a statewide contract for state agencies to ensure compliance with Title VI.
Practice Guide - Appendix F

RELATIVES AND FRIENDS

If a client is unable to act on his / her own behalf, help of responsible relatives or other appropriate persons should be sought.

Out of Home Placements

Emergency Room / Board / Supervision

APS has a small amount of money allotted in the DPA for Adult Family Homes that may be used to pay for temporary emergency placements for APS clients. An agreement should be completed in advance between APS staff and the licensed provider that allows for a placement of a client or allows the client to receive in-home supervision services. The FSI must attempt to negotiate a rate of less than the maximum of $200 per 24 hour period. There must be no other resources available to pay for this placement. All other options must have been researched and exhausted. Approval from APS state office staff is required for every case. Placement can be a nursing home, boarding home, respite, assisted living, or an in-home provider such as home health or a sitter service, etc. This placement option is to be used only as a last resort.
Practice Guide - Appendix F)

Hospitalization

There may be times when the client's physical or mental condition indicates a need for medical care, including hospitalization. The Diagnostic Related Group (DRG) is a uniform code for reimbursement used by hospitals to categorize

patient admissions. See list of DRG codes and "Standards for Hospitals" rules in Service Provision Practice Guide.

Nursing Home Placements

The following activities must be conducted prior to seeking legal custody of an adult for placement in a nursing home:

- An approved Pre-Admission Evaluation (PAE) must be obtained including the PASAAR.
- APS staff must gather information about the client's resources to determine if private pay is an option.
- If private pay is not an option, APS staff must gather information and make contact with the appropriate Family Assistance staff to determine if the client would likely qualify for Medicaid. See FA Contacts

NOTE: If client receives SSI, they will qualify for Medicaid.

Staff must not advise an APS client or his / her family regarding the disposition of property in order to qualify for Medicaid or any other programs. However, counselor may refer client or his/her family to the Family Assistance Program for hardship consideration.

Upon placement of an adult in a nursing home who is in the legal custody of the Department, the following must be completed:

- APS staff must ensure that a Medicaid application is filed on the day the client is admitted to the nursing home. The Patient Care Advocate may be contacted for possible assistance if there are problems.
- APS staff must remain actively involved to ensure that the application for Medicaid is processed and a determination is made.
- Nursing Home Waiting Lists - Emergency Placements to bypass
- Third Party Signatures - A nursing home cannot require a third party signature, as a condition for admission to the facility, for a Medicaid or Medicare recipient. When the Department has custody of an adult who is placed in a nursing home or other long-term care facility, the counselor cannot sign any form(s) which would make the Department financially responsible for the costs of the adult's care. At the custody hearing, a temporary guardian may be appointed to handle the adult's finances.
- Emergency Approval of Pre-Admission Evaluation (PAE)

Relocation

In situations in which the client needs to leave or be removed from an unsafe situation – either due to the physical home environment or an abusive arrangement – considerations may include:

- Assistance in finding other places to live (with relatives, friends, shelters, etc.)
- Assistance in obtaining special care or supervision (residential homes, nursing homes, foster homes, etc)
- Court intervention and DHS becoming the decision maker regarding the placement.
- Transporting the client and/or the client's possessions to an alternative living arrangement with the consent of a client or with proper legal authority.

Without the client's consent, a move can be made only by order of the court.

A client who is capable of understanding his / her situation may make the decision to continue living in a residence which APS believes to be unsafe.

Relocation to Unlicensed Facilities is Prohibited.

APS staff must not assist an adult with moving into an unlicensed facility. A client who is capable of understanding his / her situation may make the decision to move into an unlicensed facility, but must do so without any assistance from APS. Click on the appropriate link to search for a licensed facility:
for a Department of Health licensed facility
http://health.state.tn.us/HCF/Facilities_Listings/facilities.htm,
Tennessee Department of Mental Health, or Department of Intellectual and Developmental Disabilities licensed facility
https://mhddapps.state.tn.us/Licensure/Inquiry.aspx?RPT=TDMHDD%20License%20Inquiry

Law Enforcement Officials

The Tennessee Code states that law enforcement shall cooperate with the Department of Human Services in the provision of protective services. Protective services as defined in the statute also include investigations of complaints of abuse, neglect or exploitation. Further, when DHS has an adult in custody and that adult leaves the placement unauthorized and APS is unable to return the adult to the placement, law enforcement shall assist in returning the adult to such placement and shall give priority in providing such assistance. T.C.A. 61-6-115

Tennessee Bureau of Investigation (TBI)

TBI assists APS in conducting joint investigations in certain cases that involve abuse / neglect / exploitation in Medicaid funded facilities. These facilities include;

- Nursing Homes
- Supportive living facilities for Intellectually Disabled clients
- Boarding Homes / Group Homes
- Assisted Living Facilities that have been funded by Medicaid dollars.

The TBI also investigates provider fraud and abuse, neglect, and exploitation which would apply to any individual or business providing medical in home services to TennCare recipients. Notification Policy - Chapter 16 and Service Provision Practice Guide - Appendix F)

Tennessee Commission on Aging and Disability

The Tennessee Commission on Aging and Disability (TCAD) has available many services and programs for aging and disabled adults. TCAD contracts with other agencies to provide the services and programs. To access any of the services and programs in this section, call 1-866-836-6678 (TENNOPT). This number is a statewide toll free number. Callers will be routed to the closest intake site.

Information and Referral (I&R)

The Information and Referral (I&R) program is established as a way to connect people to health and human services needs, as well as provide information of a more general nature. I&R specialists, on the community level, help a caller find out what is needed and then the best way to get help. The specialists are trained to determine whether a caller may be eligible for certain programs, to help in crisis situations, and provide extra help when needed. An easy way to access services is to call the **TENNOPT** line at **1-866-836-6678**.

Congregate Meals

Meals provided at a nutrition site, such as a senior center, community center, church, etc.

Long-Term Care Ombudsman

This program is contracted to various agencies throughout the State by the Tennessee Commission on Aging and Disability. The Ombudsman works with patients and families facing barriers to long-term care. These adults may be in nursing homes, as well as board and care facilities. The Ombudsman can play an integral and vital role with the DHS counselor and the Adult Protective Services client because of his / her ability to investigate and resolve complaints made by and on behalf of older persons who are in long-term care facilities. Practice Guide - Appendix F

National Family Caretaker Support Program (NFCSP-Title III-E)

This statewide program is available through contracts with Tennessee Commission on Aging and Disability. The program is designed to help persons who are providing assistance to an elderly person (family caretaker) and thereby prevent or delay nursing home placement of the elderly person. All services are designed to ease caretaker burden and provide needed support to unpaid caretakers. The APS client must be age 60 and over and a referral can be made by calling 1-866-836-6678. Practice Guide - Appendix F

Public Guardianship Program for the Elderly

This program is contracted to various agencies throughout the State by the Tennessee Commission on Aging and Disability. The service is free; however, the court may order a fee appropriate to the client's resources. See Service Provision Practice Guide for names and locations of Public Guardians.

- **Conservatorship Program**
  The clients served through the district public conservatorship program must be 60 years of age or older, have been deemed unable to make decisions and/or care for him / herself and have no other available resources to provide this service. Acceptance into this program requires a court order.

  It may also be possible for APS to locate responsible relatives or friends of the adult who may be willing to assume the role of conservator and who will initiate the necessary legal action to establish the conservatorship on behalf of the adult.

- **Power of Attorney**
  In some cases a client may not need a conservator but may need a responsible party to make certain decisions by execution of a Power of Attorney by a client who has the capacity to do so. In some areas of the state the Public Guardianship Program may provide this service to clients who are age 60 or older.

Pharmaceutical (RX) ASSIST

This is a free service to assist people in obtaining necessary medications that they are unable to afford. In order to make a referral, APS staff should call 1-866-836-6678.

State Health Insurance Assistance Program (SHIP)

This statewide program is available through contracts with Tennessee Commission on Aging and Disability. The program provides free and objective counseling and education on Medicare and other health insurance issues. Call 1-866-836-6678 to make a referral.

Home Delivered Meals

There are three government funded programs that offer home delivered meals, sometimes referred to as Meals on Wheels (MOW). These programs are designed to promote adequate nutrition through the provision of one or more meals (hot, cold, canned, or frozen) five days a week delivered to the residence of an eligible consumer. The meals are free to qualifying persons; however, some providers suggest a donation amount. A referral can be made to any of the three programs by calling 1-866-836-6678. Practice Guide - Appendix F

NOTE: There may also be churches and other local resources that offer home delivered meals.

Homemaker Services

There are four (4) government programs that offer homemaker services. These programs are designed to provide in-home assistance with household activities. Homemaker services are limited to in-home personal care services designed to allow a participant to remain in his / her own residence and maintain independence. Homemakers can be accessed by calling the toll free number, 1-866-836-6678. For more information about the APS Homemaker Program, see section under DHS. Practice Guide - Appendix F

Medication Management

This statewide program is available through contracts with Tennessee Commission on Aging and Disability. This program is designed to provide medication management, screening, and education to prevent incorrect medication use and adverse drug reactions. This program offers a registered nurse who is available for group presentations and/or individual counseling on medication issues such as medication regimen, proper storage, potential interactions, managing side affects, compliance aids, safety precautions, and individual concerns. Call 1-866-836-6678 to make a referral.

CHOICES---Long Term In-Home Care

This statewide program is available through Tenncare/Medicaid. This program is designed to be an alternative to nursing home placement and to provide functionally impaired adults with community based, cost-effective alternatives to nursing facility care. In order to be approved for services, the client must pass a PAE and be Medicaid eligible. As with nursing home services, estate recovery may apply since this program is also funded by Medicaid. If a client already has Tenncare, call his/her Managed Care Organization (MCO) to make a referral. If the client does not have Tenncare/Medicaid, call 1-866-836-6678 to make a referral for Tenncare/Medicaid assessment. Some clients may need assistance with this process and the APS staff may contact the local Family Assistance staff to assist with Medicaid determination. For a list of services and eligibility requirements, see the Service Provision Practice Guide. For information on the Tenncare Estate Recovery, see http://www.tennessee.gov/tenncare/estate.html

Staff must not advise APS clients or their families regarding the disposition of property in order to qualify for Medicaid or any other programs.

State Funded Home and Community Based Services (HCBS), OPTIONS Program

This statewide program is available through contracts with Tennessee Commission on Aging and Disability (TCAD). This program is intended to provide in-home assistance to functionally impaired adults to enable them to remain independent in their own homes and communities with an enriched quality of life. Clients in active APS cases receive priority in this program per TCAD policy. See Services Practice Guide for more information on eligibility and APS priority. Call 1-866-836-6678 to make a referral.

There are three (3) services available:

- Personal care
- Homemaker services
- Home-delivered meals

Tennessee Department of Human Services

There are services within DHS that may be accessed in order to assist the APS client. More information about the following services is located in the Service Provision Practice guide. Appendix F

Homemaker Services

Homemaker services are available for APS clients only through DHS. This program is designed to provide in-home assistance with household activities. Homemaker services are limited to in-home personal care services designed to allow a participant to remain in his / her own residence and maintain independence.

A special referral process is required for APS Protective Homemaker Services and is authorized by completing the following tasks:

- Complete a homemaker referral form (HS-2972)
- Complete an authorization form (Form 567)
- Submit both completed forms to the agency contracted to provide protective homemaker services in your area
- Coordinate the first visit. The APS counselor must go with the homemaker on the first visit to introduce the homemaker to the APS client if the homemaker is new to the client and has not provided services for him / her in the past or the homemaker agency sends a homemaker and APS is not notified of the visit.

It is possible for an APS case to be closed and homemaker services to continue. APS staff must complete the termination Form 905, documenting the need for continued homemaker service and submit it to the homemaker agency. The Form 905 is also used to terminate homemaker services at any time while the case is open.

(See Service Provision - Practice Guide for more information on homemaker services).

Low Income Home Energy Assistance Program (LIHEAP)

LIHEAP provides funds to the states to help meet the utility costs of low-income eligible elderly and disabled adults. Click here for LIHEAP providers.

Weatherization Assistance Program (WAP)

This federal program provides funds to States to assist with the weatherization of the home of low income elderly and disabled adults and families. Applicants must meet low income eligibility guidelines based on established federal poverty guidelines. Services include insulation, storm windows, caulking, and other related activities to reduce home energy costs and increase home energy efficiency. Click here for list of WAP providers.

Council for the Deaf

The Tennessee Council for the Deaf and Hard of Hearing (TCDHH) has the responsibility for ensuring that state and local public programs and services are accessible to deaf, hard of hearing, late deafened, and deaf blind citizens. TCDHH coordinates communication, information, public awareness, and advocacy services through six regional community service centers.

Disability Determination

The Tennessee Disability Determination Services (TDDS) is a section within the Division of Rehabilitation Services of the Department of Human Services. The DDS operates by agreement between the State of Tennessee and the Social Security Administration to process Social Security and Supplemental Security Income disability claims.

Vocational Rehabilitation Services

Vocational Rehabilitation is a federal and state funded program providing services to help individuals with disabilities enter or return to employment. It is designed to assist adults of working age with physical and/or mental disabilities to compete successfully with others in the work environment.

- **Rehabilitation Teaching Program**

  The Rehabilitation Teaching Program is designed to provide services to individuals of all ages who are blind or visually impaired to better enable them to live independently in their homes and communities.

- **Services for the Blind and Visually Impaired**

  Specialized services are available for persons who have dual sensory impairments.

Tennessee Technology Access Program (TTAP)

The Tennessee Technology Access Program (TTAP) is a statewide program designed to increase access to, and acquisition of, assistive technology devices and services. Go to TTAP

Tennessee Department of Health

T.C.A. § 71-6-113 states that when the Department of Human Services is unable to find a resource for any person in need of protective services who, because of mental or physical illness, mental retardation or developmental disabilities, is in

need of specialized care or medical treatment, the Department of Health shall, based upon available resources, give priority to such person for appropriate placement or treatment if such person is eligible for placement.

Patient Care Advocate

The Patient Care Advocate is located in the Tennessee Department of Health in Nashville. The Patient Care Advocate may work with APS staff in 5 areas including:

- abuse/neglect cases in long-term care facilities when the Health Care Facilities staff is involved and the patient requests the assistance of the advocate;
- adults requiring long term care are inappropriately placed;
- problems and concerns with Pre-Admission Evaluations (PAEs);
- Medicaid discrimination matters; and
- financial problems of adults in long-term care facilities.

Healthcare Facilities

The Department of Health (DOH) is responsible for licensing healthcare facilities such as nursing homes, assisted living, Home for the Aged, and hospitals. They also license home health agencies, hospice, and home medical equipment providers. DOH certifies Intermediate Care Facilities (ICF) for the mentally challenged population. DOH accepts referrals of abuse / neglect / exploitation of patients residing in a licensed or certified facility from anyone with concerns. Practice Guide - Appendix F

Vulnerable Person's Registry

The Department of Health is responsible for maintaining the Vulnerable Person's Registry. This registry includes the names of individuals who have been determined, after due process, to be the perpetrators of abuse, neglect or exploitation of a vulnerable child or adult. Investigations Policy - Chapter 6 and Practice Guide - Appendix B

Health-Related Boards

The Division of Health Related Boards, also within the Department of Health, provides administrative support to the twenty-six (26) boards, committees, councils and one (1) registry that are charged with the licensure and regulation of their respective health care professionals, as well as the Office of Consumer Right to Know. Examples of licensing / regulating boards include, but are not

limited to: nurses, nurse's aides, doctors, physical therapists, etc. Practice Guide – Appendix F

Tennessee Department of Mental Health (TDMH) and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD)

TDMH may be available to provide services to clients who have mental health issues or developmental disabilities. Some of the services are provided directly by TDMH and some are contracted. Some of the services include:

- Crisis services
- Mental health counseling
- Housing services
    - Supportive Living Housing Program
    - Assisted Living Permanent Supportive Housing Program
    - Independent Living Assistance
    - Coordination of housing
- Speakers Bureau
- Criminal Justice Liaison
- Case Management
- TDMH Ombudsman
- Office of Consumer Affairs—helps to resolve issues
- Assistance with obtaining medication
- Peer Support Centers (formerly called Drop-In Centers)
- Support / Education / Transportation / Homelessness(SETH)
- Projects for Assistance in Transition from Homelessness (PATH)
- Tennessee Mental Health Safety Net

T.C.A. § 71-6-113 states that when the Department of Human Services is unable to find a resource for any person in need of protective services who, because of mental or physical illness, mental retardation or developmental disabilities, is in need of specialized care or medical treatment, TDMH shall, based upon available resources, give priority to such person for appropriate placement or treatment if such person is eligible for placement.

In the event that situations arise in which the APS social counselor is unsuccessful in obtaining these services, the steps below shall be followed:

- Notify the APS supervisor who will attempt to resolve the issue by working with representatives from Mental Health at the local level.
- APS program supervisors should attempt to resolve issues by working with Mental Health at the regional level. If issues remain unresolved:
    - Notify APS State Office utilizing the *Adult Protective Services Request for Assistance from the Tennessee Department of Mental Health.* *hs-2988*
    - APS State Office will request assistance at the state level.

Mental Health Crisis Team

The Crisis Team should be called in a psychiatric emergency to make the decision as to whether hospitalization or in-patient stabilization is necessary. Referral to the Crisis Team should be made when a mental illness crisis is suspected and should be based on the behaviors an individual is currently exhibiting, *i.e*., homicidal, suicidal, hostile, aggressive, threatening, responding to stimuli others can't hear or see, or disorientation (due to mental illness) to the extent of endangerment to themselves or others.

The mental health crisis line operates 24 hours a day, 7 days a week and is open to anyone who needs mental health crisis services. The call is routed to the closest crisis team. If all teams are busy, the line rolls to a backup line that can either handle the call or contact crisis workers in the caller's area for direct intervention. Someone is always available to answer and locate crisis services. In order to make a referral APS staff should call the statewide toll-free number, 1-800-809-9957. Practice Guide - Appendix F

For more information on APS clients and judicial mental health commitments, see the Legal Intervention Policy, "Mental Health Commitments."

Tennessee Department of Intellectual and Developmental Disabilities

The Tennessee Department of Intellectual and Developmental Disabilities (DIDD) is the state agency responsible for providing services and supports to Tennesseans with intellectual disabilities. Programs include:

- Consumer-directed supports
- Case management Home and Community Based Waiver Programs (requires an approved DIDD PAE / PASSAR which is a different PAE than the nursing home and the HCBS PAE)

- Statewide
- Self-Determination

- Family support

Utilization of DIDD Services in an Emergency Situation

There are times when APS clients need the services of DIDD. In order to access DIDD services using the form listed below, the client must meet one of the criteria below:

- Homeless
- Without a primary caretaker due to death or incapacitation and lack of an alternate primary caretaker
- Presents serious and imminent danger to self or others
- Experiencing multiple (two or more) urgent issues that are likely to result in a crisis if not addressed immediately.

T.C.A. § 71-6-113 states that, when the Department of Human Services is unable to find a resource for any person in need of protective services who, because of mental or physical illness, mental retardation or developmental disabilities, is in need of specialized care or medical treatment, DIDD shall, based upon available resources, give priority to such person for appropriate placement or treatment if such person is eligible for placement.

See the Service Provision Practice Guide - Appendix F for more information and complete definition of the above criteria and for information on decision making for people with intellectual disabilities.

If the APS client meets the criteria above and there are challenges obtaining those services, the following steps should be taken:

- Notify the APS supervisor who will attempt to resolve the issue by working with representatives from DIDD at the regional level.
- APS program supervisors should attempt to resolve issues by working with DIDD at the regional level. If issues remain unresolved,
- Submit documentation and request for a re-evaluation of the client's needs to DIDD Central Office.

If issues still remain unresolved:

- Notify APS State Office utilizing the *Adult Protective Services Request for Assistance Tennessee Department of Intellectual and Developmental Disabilities*. (hs-2987).
- APS State Office will request assistance at the state level.

The services described above are funded programs that are statewide. There may be other resources available to APS clients in the local community.

Chapter 11
LEGAL INTERVENTION POLICY

Legal Authority

T.C.A. § 71-6-101 et seq., T.C.A. § 34-11-101 et seq., T.C.A. § 34-12-101 et seq., T.C.A. § 34-13-101 et. seq., T.C.A. § 33-6-103, T.C.A. § 33-6-104, and T.C.A. § 36-3-601

Purpose

There are several options under the Tennessee Adult Protection Act (the Act), Tenn. Code. Ann. §§ 71-6-101 et seq. which allow the Department to pursue court intervention in order to complete an investigation of an APS referral and in order to provide protection to clients who are determined to be in need of protective services. The options should be carefully considered before withdrawing from an investigation or terminating services in any case situation in which a client is thought to be in need of protection but does not consent to or withdraws consent for service.

Policy

The decision to take legal action is made as a last resort after all considerations have been taken into account and all practical alternatives to legal action have been exhausted. Any time there is reason to question whether or not a client is in imminent danger, careful review of the client's capacity to make decisions must be made. The specific authority requested and granted will be based on the needs of the client and on the level of danger. Immediate threat of danger allows for the most intrusive legal action. In the absence of immediate danger, less intrusive court intervention must be considered.

APS staff should in no instance attempt to give legal advice to persons who contact us. Nor should they refer anyone to a particular private attorney outside DHS Legal. The only advice staff can give with regard to legal representation is to simply recommend that the person seek the advice of legal counsel.

Requirements for Accessing the Court

- There is no other less drastic alternative to the particular action being considered, such as placement with relatives, home health care, or other home-based services that will allow the client to remain safely in the client's home and that will adequately protect the client from imminent danger of abuse, neglect or exploitation. Temporary restraining orders and orders of protection should be considered as an alternative to seeking custody of the individual.

- Approval of Supervisor has been obtained.
- The DHS Attorney for your district, or in that attorney's absence, the State Office legal staff, has been consulted regarding any necessary evidence to support legal action.
- Legal referral has been ***completed***. Depending on the type of court action, varying information is required. However, although in serious emergencies, information may be provided by phone, e-mail or fax if the situation demands, with a follow-up formal written referral to follow immediately, ***all*** information in any legal referral necessary and relevant to the legal action requested ***must*** be completed before it is sent to the Department's legal staff. Practice Guide - Appendix G
- Facts provided in the referral to initiate the legal action requested ***must*** meet the standard of proof necessary to successfully prosecute a case under the Adult Protection Act. (Preponderance of Evidence or Probable Cause depending on the action taken).

Failure to provide the necessary facts, or the failure to provide accurate and complete facts and evidence, such as detailed medical / psychiatric / psychological information and the detailed statements of other witnesses to support the determination of lack of capacity and imminent danger of harm will result in delay in providing the requested legal service or disapproval of the requested legal action.
It is the responsibility of the social counselor and the supervisor to provide all necessary information in the legal referral needed for legal approval of the requested legal action on behalf of the client. If there is uncertainty about what evidence may be needed to initiate legal action, the attorney must be consulted early in the investigation so that delays can be avoided.

Providing Protective Services without the Consent of the Client

Basis for Legal Intervention to Provide Protective Services

If the Department determines that a client is in need of protective services and lacks capacity to consent to protective services, then the Department may file a complaint with the court asking for an order to authorize the provision of protective services, and, if the client is in immediate need of protective services to prevent irreparable harm or death, the Department may seek immediate legal custody of the client to provide and consent to those services.

Legal intervention may be initiated at any time during investigation or while on-going services are being provided if evidence supporting (1) the lack of capacity to consent to protective services and (2) Imminent danger of harm is provided to

the legal staff of the Office of General Counsel to support the requested legal action.

Definitions of Key Terms Used in Determining the Need for Court Intervention

The term "protective services" (T.C.A. § 71-6-102(11) means:

> Services undertaken by the Department with or on behalf of a client in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to, conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the client in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; services directed toward seeking legal determination of whether the client in need of protective services has been abused, neglected or exploited and procurement of suitable care in or out of the client's home.

The term "capacity to consent" (T.C.A. § 71-6-102(4) means:

> The mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts. A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent.

This definition was originally developed by the Tennessee Court of Appeals in its opinion in ***DHS*** *vs.* ***Northern*** (563 S.W.2d 197, 1978). The court furthered clarified the definition of capacity as follows:

> "A person may have 'capacity' as to some matters and may lack 'capacity' as to others."
>
> "A blind person may be perfectly capable of observing the shape of small articles by handling them, but not capable of observing the shape of a cloud in the sky."

It is possible for a person to be generally of sound mind and lucid, but in one area of his / her life, comprehension may be "blocked, blinded or dimmed to the extent" that he / she is "incapable of recognizing facts which would be obvious to a person of normal perception."

> In the *Northern* case, Ms. Northern was able to describe many things or respond to questions that any other person would be able to do. However, her legs had become infected with gangrene to the point that the legs were black, yet she maintained that her legs were just dirty and that she would recover and

refused to consent to medical treatment. While lucid regarding certain things, she did not recognize the life-threatening status of her medical condition. Had Ms. Northern stated clearly: “Yes, I see that my legs are badly infected, and I also understand that that condition will likely result in my death if I do not immediately receive medical treatment,” then her wishes would have been respected and further actions by the Department to require the provision of protective services would not have occurred, even if most people would have chosen medical treatment. In this respect she was cognizant of some things, but blind to her own peril to the point that she was unable to “perceive, appreciate all relevant facts and to reach a rational judgment upon such facts.”

The Court of Appeals based its decision in part on the following statement of her doctor regarding Ms. Northern’s ability to make a rational decision as to her condition:

> On January 26, 1978, there was filed in this cause a letter from Dr. John J. Griffin, reporting that he found the patient to be generally lucid and sane, but concluding:
>
> Nonetheless, I believe that she is functioning on a psychotic level with respect to ideas concerning her gangrenous feet. She tends to believe that her feet are black because of soot or dirt. She does not believe her physicians about the serious infection. There is an adamant belief that her feet will heal without surgery, and she refused to even consider the possibility that amputation is necessary to save her life. There is no desire to die, yet her judgment concerning recovery is markedly impaired. If she appreciated the seriousness of her condition, heard her physicians' opinions, and concluded against an operation, then I would believe she understood and could decide for herself. But my impression is that she does not appreciate the dangers to her life. I conclude that she is incompetent to decide this issue. A corollary to this denial is seen in her unwillingness to consider any future plans. Here again I believe she was utilizing a psychotic mechanism of denial.
>
> This is a schizoid woman who has been urged by everyone to have surgery. Having been self-sufficient previously (albeit a marginal adjustment), she is continuing to decide alone. The risks with surgery are great and her lifestyle has been permanently disrupted. If she has surgery there is a tremendous danger for physical and psychological complications. The chances for a post-operative psychosis are immense, yet the surgeons believe an operation is necessary to save her life. I would advise delaying surgery (if feasible) for a few days in order to attempt some work for strengthening her psychologically. Even if she does not consent to the operation after that time, however, I believe she is incompetent to make the decision.

Northern at 203.

The doctor's description illustrates very well the elements of lack of capacity as used in the Adult Protection Act that must be found to permit legal intervention by the Department.

Absent a showing that the client lacks capacity, he /she has a right to make his / her own decisions and does not have to make decisions which necessarily seem reasonable to others. The client only has to show that he / she:

- Comprehends the facts of his / her condition,
- Comprehends the impact of the decision, and
- Understands and accepts the results of the decisions which are made.

Example: A person who understands his / her condition and recognizes that he / she will die if without surgery, but still chooses not to have the surgery, will be allowed to make such a choice.

In order to assist in determining whether or not a client has the capacity to make decisions for him / herself, the following three questions must be addressed:

- Does he / she know what his / her condition is?
- Does he / she know the consequences of refusing the needed care / treatment and/or services?
- Does he / she understand and accept the consequences of his / her decision?

The counselor will assess the situation on his / her observations and observations of persons in a position to know of the client's appearance, behavior, symptoms, and orientation to reality, lack of rational thinking and other such information. The counselor will also seek opinions from other professionals - psychiatrists, physicians, psychologists, public health nurses, social workers, etc. The object of the observation and investigation is to make a sound judgment as to whether or not the client is able to make the decision.

If it is clear that the client has the capacity to make his / her own decisions, then court action is not possible. If it is not clear, then a staff attorney should be contacted to consider obtaining an order to have the client examined to make this determination.

The term "imminent danger" (T.C.A. § 71-6-102(9) means:

> Conditions calculated to and capable of producing within a relatively short period of time a reasonable probability of resultant irreparable physical or

mental harm or the cessation of life, or both, if such conditions are not removed or alleviated.

The statutory definition is based upon the interpretation of the definition of “imminent danger of death” as determined by the Tennessee Court of Appeals, in *Department of Human Services vs. Northern* (563 S.W.2d 197, 1978.)

The Court recognized the vagueness of the phrase “imminent danger of death,” but concluded that it is no more vague than the subject matter, as courts, legislative assemblies and physicians have struggled to define "death."

The opinion of the Court of Appeals in the *Northern* case included the following comments:

> "Danger is a word of many degrees. It may imply strong or weak probability or mere possibility, according to the context of circumstances." "Imminent means close in point of time, but closeness is likewise a term of many degrees, according to the circumstances."
>
> **"For an authorization to mildly encroach upon the freedom of the individual, a relatively mild imminence or danger of death may suffice. On the other hand, the authorization of a drastic encroachment upon personal freedom and bodily integrity would require a correspondingly severe imminence of death."** *Northern* at 209.

In practice, when considering the degree of imminence required for a specific action to be justified, the degree of encroachment upon personal liberty must also be weighed.

For example, requesting a court order to consent to a temporary protective placement during dangerously cold weather would require less of a threat than an order to consent to amputation. Amputation is considered one of the most extreme examples, as is any other action or medical treatment which is very risky or permanent and irreversible. Amputation would require a strong imminent danger of irreparable harm or death.

“Custody” as used in the Adult Protection Act means:

> The Department or other person or entity legally responsible for the client's welfare is authorized to assume legal and physical control over the client to have the client transported to and/or retained in a hospital, nursing home, etc. and to consent to the provision of any protective services ordered or permitted by the court’s order to prevent irreparable harm or death to the client.

Custody does not mean that the Department or APS staff has any authority to assume control over the client's financial or physical assets. If such authority is necessary, a temporary guardian as authorized under the Act must be appointed, or a referral to the Office of General Counsel must be made to petition for a conservator to assume control of the client's financial affairs.

The Department only has such custodial authority as is authorized in the court's order which may include specific authority to consent to have the client hospitalized or placed in a nursing home and to consent to specific or general medical or nursing care. If, after custody of the client is placed with the Department, additional services, such as major operations or life-saving measures, are necessary, APS must seek additional authority from the court to consent to those services.

When available, other alternative living arrangements may be authorized in the court's order, such as, residential homes or Family Homes for Clients.

"Resources" includes:

The means to pay for medical / nursing home care through private insurance, TennCare / Medicaid / Medicare, or to pay for those services or others through liquidations of assets, or the ability to access needed services provided by other state or private agencies. Under the Adult Protection Act, the Department is not required to provide protective services unless those services are funded in some manner, and the Department should not proceed to obtain court authority to provide services or to assume custody of a client unless the availability of resources to provide such services has been determined. **(T.C.A. §§ 71-6-103(g), 107(a)(6), 109, 111, and 112)**

Legal Requirements for Ordered Protective Services

Non-Custodial Court Orders to Provide Protective Services

The law provides for court intervention on behalf of a client who does not consent, or who withdraws his / her consent, to services when the Department determines that the client is in need of protective services and lacks the capacity to consent to protective services, but the need for services and the client's physical / mental status do not legally support seeking legal custody of the client to provide services.

For a non-custodial order, the client must:

- Be in need of protective services; and

- Be shown to lack the capacity to consent to protective services; and
- Resources and a way to administer those resources must be available to provide the protective services

When Non-Custodial Orders to Provide Protective Services Are Used:

- In an on-going case in order to obtain authority to consent to services in a non-emergency situation. This route is typically used to authorize in-home services if non-custodial services will be sufficient to provide protection to the client who is not in imminent danger of harm.

Notice and Right to Counsel

In a case in which the Department files a complaint to obtain an order to permit the Department to provide protective services to the client without taking legal custody of the client because imminent danger of harm does not exist, the client ***and*** spouse must receive 10 days notice of the hearing. Failure to notify the spouse can lead to financial sanctions against the Department.

There is a right to counsel for both the client and the spouse in this type of court proceeding. If the client is indigent, or the chancellor or judge determines he / she lacks capacity to waive the right to counsel, then the court will appoint counsel for the client. The court is not required to appoint separate counsel for the spouse nor is the Department required to pay for counsel for the spouse unless the court finds that the Department has failed to properly attempt to notify the spouse.

If the client is indigent, the court can order the Department to pay court costs and attorneys fees.

Custodial Orders to Provide Protective Services

The law provides for court intervention on behalf of a client who does not consent, or who withdraws his / her consent, to services when the Department determines that the client is in need of protective services, lacks the capacity to consent to protective services and the need for services and the client's physical / mental status legally support seeking legal custody of the client to immediately provide services.

To justify requesting a court order for custody– Practice Guide - Appendix G.

The client -

- Must be in need of protective services; and
- Be shown to lack the capacity to consent to protective services; ***and***

- Be shown to be in imminent danger of irreparable physical or mental harm or death to such a degree that immediate action must be taken to provide protective services to alleviate the danger;

NOTE: If a person who is terminally ill has a living will, the Department cannot seek custody to provide medical care which would conflict with the terms of the living will. However, if the medical care that is to be provided does not present such a conflict, then custody can be obtained for that purpose. .

Other requirements -

- The Department must have made **reasonable** efforts to exhaust all practical alternatives to removal from the home or current placement – including consideration of a non-custodial order allowing the Department to consent to protective services while the client remains at home or other placement. These efforts must be described in any legal referral seeking custody of the client;

- Resources to fund protective services for the client must be available. If resources are not available to provide protective services, the Department is not required to provide the protective services. If the client has resources that need to be managed, see Temporary Guardianship below.

- The Department, or other person or entity given custody of the client, is responsible for the client's physical care until relieved by the court, even if the immediate imminence of danger has been alleviated.

NOTE: There will be instances in which the Department will petition for custody of a client based on allegations of sexual abuse. If the Department does not believe removal is appropriate or does not have grounds for taking custody, there may be other legal action which may be taken. One option is to discuss with the supervisor and the staff attorney filing a petition to have a conservator appointed or to seek injunctive relief, such as a temporary restraining order or temporary or permanent injunction, or to assist the client in seeking an order of protection.

While prosecution of a perpetrator may be a desirable goal, it is not the foremost goal of APS. Protection and safety of the client must be our primary goal, and all avenues must be explored to successfully achieve that end.

Custody may be sought at any point in a case when an immediate custody order is needed in order to address a client's urgent need for protective services such as medical treatment, hospitalization, surgery, nursing home care, protective residential / foster care placement, etc.

Medical Evidence

The development of appropriate medical / psychiatric / psychological evidence is critical to establish the proof necessary to determine the propriety of providing

protective services to a client through legal action. The evidence must be sufficient to prove that the client lacks the "capacity to consent" when requesting legal action for a custodial, non-custodial, or conservatorship order as well as the existence of "imminent danger" for custodial and conservatorship orders.

The Department's attorney is ultimately responsible for both initiating legal action on behalf of the State to provide protective services to the client and for presenting sufficient evidence to the court to sustain the Department's allegations under the Act. There is often the need for expediency in developing the necessary evidence in many cases due to the imminence of danger to a client. DHS' legal staff should be involved in the case as early as possible, utilizing the following procedures:

- APS staff will notify the staff attorney for their area as early as possible during the investigation of the case and, in particular, as soon as the APS staff begin to consider the possible need to recommend that legal action be taken on behalf of the client, in order to identify the medical / mental health professionals who may have been treating or who have examined the client at that point. This will allow the staff attorney to assist, at the beginning stages of the case or early in the process leading up to a legal referral, with development of specific factual evidence to support allegations that the client lacks capacity to consent to protective services and that the client's medical conditions demonstrate imminent danger of irreparable harm or death.

- To the extent possible, APS staff will consult with legal staff prior to seeking formal written medical opinions, such as on the Form 1125 or in the form of a letter directed to APS staff. If, however, written statements either in the form of letters or medical records exist, these will be provided for the staff attorney's review as early in the development of the case as possible so that the attorney can review them to determine if they provide the appropriate information to make a determination of the client's capacity and the danger presented by the client's situation.

- At the same time, APS staff will give the attorney any relevant facts that provide a clear description of the client's social history that may be relevant to the formation of the medical / mental health professionals' opinions regarding the need for protective services for the client.

- Upon receipt of this information, the staff attorney will communicate directly with the medical / mental health professionals in order to ensure that both the facts and the conclusions of treating and examining professionals support the two legal standards necessary to assume custody of the client for the provision of protective services.

This communication by the staff attorney will be directed towards:

- Relating the social history of the client to give background for provision of the professional's opinion;
- Clearly explaining to the professional the two critical legal standards necessary to obtain custody of the client and determining the professional's understanding of those standards;
- Asking questions necessary to elicit the specific facts underlying the professional's opinion regarding the medical / mental health diagnosis / status of the client to determine if the facts support the medical / mental health professionals' opinions.
- Asking questions of the professional to determine specific facts to support a finding of:
    - The lack of capacity of the client to consent to protective services;
    - Imminence of harm to the client – what will happen and how quickly;
    - The reasonable probability of such harm to the client without immediate alleviation of the conditions affecting the client;
    - What the prognosis for the client will be unless the conditions concerning the client are not remedied immediately if the client is not removed from those conditions, or, in the event of a client who is hospitalized or receiving nursing care, if the client is returned to the situation existing previously.

If the facts establish the basis for the professional's opinion on these questions, the attorney / social counselor will request that the professional complete an 1125 or letter addressed to the attorney that contains the above information.

- The attorney will record in the legal case file, and provide to the APS staff in the form of a memorandum, the results of the discussion with the medical / mental health professional and will provide any written statement of the professional. The attorney will also enter this information in the automated system.

For presentation of evidence in court to support lack of capacity and imminence of harm, the attorney will:

- Determine if the medical / mental health professional will testify in person and issue any necessary subpoenas;
- Take a deposition of the professional;
- Seek a stipulation of the professional's opinion, with supporting facts, for presentation to the court, or

- Seek agreement with opposing counsel:
    - To allow the admission of the written statements of the professional obtained by the staff attorney;
    - To permit the introduction of an affidavit attached to that statement;
    - Allow the introduction of an affidavit from the professional that separately describes the facts as previously obtained and the professional's opinion based upon those facts; or
    - Allow the introduction of medical/mental health records of the adult.

Notice and Right to Counsel

When a complaint for protective custody of the client is filed, the client and his / her spouse must receive at least 48 hours notice of the hearing, unless for good cause shown, a shorter time is allowed by the court, such as approval for immediate medical care necessary to save the client's life.

If an emergency ex parte order is issued, a subsequent hearing must be held within 7 days unless an extension to 15 days is granted by the court.

The client and his / her spouse have a right to be present at the hearing and to be represented by counsel. If the client is indigent, or the chancellor or judge determines he / she lacks capacity to waive the right to counsel, then the court will appoint counsel for the client. The court is not required to appoint separate counsel for the spouse, nor is the Department required to pay for counsel for the spouse unless the court finds that the Department has failed to properly attempt to notify the spouse.

If the client is indigent, the court can order the Department to pay court costs and attorneys fees.

Miscellaneous Legal Processes / Procedures Available to APS

Search Warrant

A search warrant may be obtained to aid the investigation of any case in which there is probable cause to believe an client is being abused, neglected or exploited. (Enter Private Premises to Investigate - T.C.A. 71-6-103(f))

When Used:

Most frequently used to complete an investigation when unable to gain access to the client because the client is unable to consent to entry or a caretaker refuses

to allow staff to enter the premises where the client is located to conduct the investigation.

Requirements:

- A referral of abuse, neglect or exploitation of an impaired client and probable cause to believe that A/N/E is occurring or has occurred;
- The inability to begin or complete the investigation due to the client's, or another person's, refusal or inability to allow entry into the home or other place where the client is located or if a person won't allow access to the client.

Note: Lack of capacity and imminent danger are not required for search warrants since the purpose of the warrant is to assist in making that determination.

Court Ordered Mental / Physical Examinations

A mental / physical exam can be requested in those cases in which there is probable cause to question a client's capacity to consent or there is reason to believe the client may be in imminent danger of irreparable harm or death, but the evidence that is currently available is inadequate to petition the court for an order granting the authority to consent to placement, treatment or other services.

NOTE: These orders provide only for examination and do not permit treatment or placement of a client without first obtaining an additional order from the court. In these circumstances, the client may be transported and hospitalized only as necessary to complete the examination and the client can only be examined for conditions described in the order. Staff cannot consent to any other examinations or treatment not related to the examination without further authorization of the court after consultation with legal staff. Once the examinations are complete, and, unless an order for protective services is granted, the client must be returned to the client's home or other placement.

Types of Orders for Court Ordered Examinations

- Orders to require the client to be examined by a physician; a psychologist in consultation with a physician; or a psychiatrist to determine either the client's capacity to consent and/or whether the client is in imminent danger of irreparable harm or death.
- Notice shall be given to the client and the client's caretaker, if any, that the Department is going to seek a court order to require a physical / mental examination.
- In emergency situations, orders may be issued without the client or caretaker receiving notice or being present ("ex parte" orders) through affidavit or sworn testimony of the APS staff if there is probable cause to

believe that the client is in imminent danger and that delay for a hearing would be likely to substantially increase the client's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life.

When Used:

Most often used during an investigation to assist in determining whether or not a client is in imminent danger and/or lacks capacity to consent to the services.

Requirements:

- APS must be investigating the alleged abuse, neglect or exploitation of the client;

- APS must be able to show probable cause that the client lacks the capacity to consent to protective services and/or is being abused, neglected or exploited; and

- If an order for a medical examination is to be requested, evidence must be available which demonstrates that there is probable cause that an adult lacks capacity to consent to protective services and is being abused, neglected, or exploited. This order may require the adult to be examined by a physician, a psychologist in consultation with a physician or a psychiatrist in order that such determination can be made. An order for examination may be issued ex parte upon affidavit or sworn testimony if the court finds that there is cause to believe that the adult may be in imminent danger and that delay for a hearing would be likely to substantially increase the adult's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life. Evidence may be obtained by the counselor's detailed observations of the client with unexplained, untreated illness or mental condition. Such evidence may be available from records or contacts with those having knowledge of the client's condition.

Sources for Payment of Court Ordered Examinations

- The client will pay the cost of the examinations from his / her own resources. Any available insurance, Medicare, TennCare or indigent medical services will be used.

- As a last resort, when all other options have been explored, eliminated, and documented, then the Department may be billed at the Medicaid rate for any necessary examinations.

- If payment by the Department is requested, it must be documented on the legal referral and approved by the DHS staff attorney prior to making arrangement for the examination.

Temporary Restraining Orders / Injunctive Relief T.C.A. § 71-6-104

A Temporary Restraining Order (TRO) or a temporary or permanent injunction can prohibit an individual or entity from taking any action prohibited by the TRO to prevent a violation of the Adult Protection Act. Temporary or permanent injunctions can also direct a person to take some affirmative action, or prohibit the person or entity from failing to take required action, as set forth in the court order, which generally would be an act or omission that is in violation of some part of the Adult Protection Act.

When Used

- When needed to ensure the protection of the client.
- At any point in the case / investigation to prevent the caretaker from interfering with provision of protective services.
- To require caretaker to disclose whereabouts of a client.
- To protect other vulnerable clients from an indicated perpetrator when the identity cannot be released without the provision of appropriate due process procedures.
- To protect the client from further contact with an indicated perpetrator, and
- May be used in other situations in consultation with a DHS attorney

Requirements:

- Need for protective services for the adult
- Evidence or knowledge which shows caretaker is interfering with necessary care or is impeding an investigation
- Preponderance of evidence that person is the perpetrator of harm or is interfering with care of the adult or is impeding an investigation

Temporary Guardianship under the Adult Protection Act T.C.A. § 71-6-107(a)(6)

A Temporary Guardian should be considered for clients who have sufficient resources and are required to pay for the court-ordered care / treatment, and for those clients without resources that need arrangements to be made for indigent care / treatment.

Whenever DHS seeks a custody order for a client who is unable to obtain the care / treatment he / she requires until someone is given access to his / her resources, the complaint should include a request for a temporary guardian to be

appointed; or, if this need arises after the complaint is filed, the Department's attorney should be advised to ask the court to appoint a temporary guardian.

This option may only be used when DHS is seeking an order for custody in order to consent to care, treatment or placement in a medical facility or alternative living arrangement.

The court may appoint a temporary guardian for such period as necessary to secure and disburse the adult's resources for the purpose of providing the necessary care in a hospital, nursing home or alternative living arrangement, but for no longer than six (6) months from the entry of the order authorizing provision of protective services. However, the court, in its discretion, may extend such period for a period no longer than an additional six (6) months. The guardian appointed under § 71-6-107(a) (6) must file an accounting with the court regarding the resources used to provide care for the client.
DHS legal staff must be contacted if it becomes necessary to extend the temporary guardian's authority and this should be done well in advance of the expiration of the service period.

The court in its order may also authorize the temporary guardian to exercise a limited power of attorney over any accounts the adult has in a bank, credit union, or other financial institution. The temporary guardian must deliver a copy of the order of the court to the financial institution prior to taking any action with regard to the accounts. The limited power of attorney shall authorize the temporary guardian to withdraw money from or freeze or unfreeze the account.

Concurrent with the order of the court appointing a temporary guardian, the court must issue a subpoena directed to the financial institution in compliance with the Financial Records Privacy Act, in title 45, chapter 10 of the Tennessee Code, requesting the names of any co-owner or additional authorized signatories on the accounts, unless the temporary guardian has actual knowledge of any co-owners or additional authorized signatories.

Upon receipt of the response to the subpoena, or upon actual knowledge of the co-owners or additional authorized signatories, the temporary guardian must send a copy of the order to any person who is a co-owner of or authorized signatory on the deposit account within ten (10) days of receiving the names of the co-owners or signatories.

Nothing, however, will prevent the temporary guardian from making immediate expenditures from the accounts of the adult necessary to provide protective services for the adult in imminent danger, as defined in this part, pending the response by the co-owners or other signatories to the accounts.

If the court finds that the temporary guardian has, without good cause, failed to provide a copy of the order to the co-owner or additional authorized signatory on the deposit account, the court may assess attorneys' fees for the benefit of the

co-owner or additional authorized signatory or court costs associated with the failure of the department or the temporary guardian; provided, that the fees and court costs shall not exceed a total of two thousand dollars ($2,000); provided, further, however, that the court may exceed the two thousand dollar ($2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars ($2,000) and that the interests of justice require that the limit be exceeded in the particular case.

A temporary guardian who is appointed as a result of a complaint filed under the Adult Protection Act does not have authority over the physical care and placement of the client.

- Provisions for a temporary guardian should be included in a final order for custody if at all possible. **DHS staff cannot serve as the temporary guardian for the APS client.** Practice Guide - Appendix G

Requirements:

- Court order to consent to care, treatment or placement has been granted to DHS; and

- The client has resources to pay for care / treatment; and

- They do not have current access to the money in order to obtain care / treatment without the appointment of a temporary guardian who will use resources to defray costs of care; or

NOTE: The APS case must remain open during the entire appointment of a temporary guardian**.**

Civil Remedy - Practice Guide - Appendix G.

In addition to other remedies provided by law, an abused, neglected, or financially exploited elder person or disabled adult has the following civil remedies available under the Adult Protection Act – T.C.A. § 71-6-120

- Recovery of compensatory damages for abuse, neglect, sexual abuse or financial exploitation if shown by clear and convincing evidence that the alleged perpetrator was responsible for the neglect, abuse or exploitation. This action can be filed by the victim, his / her conservator or personal representative. This right is not extinguished by the death of the victim. Damages awarded by the court can include costs, including attorneys' fees and court costs, in addition to compensatory damages.

- The recovery of money or property of the elderly or disabled adult, if shown by clear and convincing evidence that the alleged perpetrator obtained it by fraud, deceit, coercion or other means. This action can be

filed by the victim, their conservator or personal representative. This right is not extinguished by the death of the victim.

- The recovery of punitive damages.

Review and Monitoring of Court Orders Granting DHS Authority to Consent to Services - Practice Guide - Appendix F

When it appears that the custody order is no longer needed in order to prevent immediate and irreparable harm or death to the client, or the client regains his / her capacity to consent to services, then DHS shall request court review of the continued need for the custody order.

For cases in which a court order gives the Department authority to consent to protective services, APS staff must**:**

- Review the case at least every 6 months in conjunction with the FS1, with consultation from DHS legal counsel if needed, and a decision must be made regarding the need for DHS to continue to have such authority. The client's condition should be continuously monitored for changes which may warrant restoration of the client's right of self-determination.
- Document the need for continuation or modification of the court order. The documentation must address: the client's capacity to consent and the risk to the client if the order is changed and his / her rights are restored.
- If the court order can no longer be justified, supervisory and legal consultation must be obtained in order to determine if a motion should be filed to relieve the Department of custody of the client. If staff believes the Department should be relieved of custody or the custody order should otherwise be modified, a legal referral describing the evidence to support the change in custody or other modification of the order must be prepared and sent to DHS legal staff.

If additional medical or nursing care not clearly within the scope of the original custody order is recommended by the client's medical / nursing providers, a referral to the DHS staff attorney for the district to seek additional legal authority from the court to provide additional or different protective services, such as for major operations, very intrusive procedures or to institute a "Do Not Resuscitate" (DNR or "No Code") order, will be necessary.

Payment for Services

The Department cannot pay the cost of the client's care (room, board, treatment). Therefore, before attempting to provide protective services, and, in particular, when seeking custody of a client, APS staff must determine if resources to pay

for those services exist. Family Assistance staff is required to assist APS staff in determining potential eligibility for TennCare / Medicaid or other benefit programs and should be asked to make an expedited preliminary eligibility determination for these programs prior to APS staff attempting to obtain custody of the client.

When the court has ordered treatment and/or a protective placement for a client, APS will secure available resources of the client to meet the needs of the client. A temporary guardian pursuant to T.C.A. § 71-6-107(a)(6) may need to be appointed by the court to liquidate the client's existing resources to pay for the client's care. The need for a temporary guardian should be determined at the time the court places custody of the client with the Department, but the temporary guardian may be appointed at any time by the court. See above discussion on legal basis and authority of the temporary guardian.

- If the client's income and resources are adequate, then it is expected that the court-ordered care should be paid from the client's resources.
- If the client does not have adequate resources to pay for the necessary services, then APS must initiate appropriate applications for income and medical coverage, such as SSI, TennCare, Medicaid for institutionalized (nursing home) care, etc.
- The Department must file for Medicaid / TennCare for the client taken into custody **no later than the first date of placement in a facility to ensure complete coverage for the client's care.**
- Full use will be made of local resources which are available to clients at reduced rates or free of charge.
- While eligibility is being determined, it may be necessary for the counselor to seek temporary help from local resources which agree to help in emergency situations, such as churches and civic groups.

Post Placement Examinations- Practice Guide - Appendix G.

Clients taken into legal custody and placed in a non-medical placement must:

- Have an examination in order to determine the cause of the condition which has resulted in the client's lack of capacity to consent. This examination(s) is always required unless such determination was made at the time of the final hearing.
- The required examination(s) should be obtained within two weeks of placement.
- Once the cause of the incapacity is determined, prescribed treatment should be arranged.

Legal Options under Other Statutes

Conservatorship

When APS becomes involved with a client who appears to be unable to manage his or her own care, property, or both, the Department may provide legal services to establish a conservatorship. A decision for the Department to act as the petitioner to establish a conservatorship will be made on a case by case basis. A legal referral must be prepared to request this legal arrangement to be established.

When Appropriate

The Department will provide legal services to establish a conservatorship ***only for clients who meet adult protective service criteria*** and only for the following reasons:

- The conservatorship would, based upon the client's particular circumstances, clearly be a more effective initial means of providing protective services to the client than use of the Adult Protection Act; or
- A conservatorship is a means of making a transition from custody of the client by the Department under the Adult Protection Act to long-term care and supervision by a suitable relative or other suitable person, and/or
- The client who is in the Department's custody under the Act has resources in significant amounts and the temporary guardian is unable to provide services under the Adult Protection Act which are required by the particular circumstances of the client, or
- The temporary guardian's term of service for a client in the Department's custody is about to expire under the terms of the Act.

When Not Appropriate

The Department will not provide legal services to establish a conservatorship for an individual who does not meet the criteria for a custodial petition, or who is not already in the Department's custody, pursuant to the Adult Protection Act, or

- When the individual only needs a conservator to manage finances or property, or
- Simply as a legal service to the client or his / her family members who may not be able to afford or do not want to expend funds necessary for the legal services to establish a conservatorship or who, for any other

reasons, do not want to undertake the legal process necessary for a conservator, or

- Because members of the community feel that the State should undertake the establishment of a conservatorship for the client.

NOTE: A Tennessee District Public Guardian may be appointed as a conservator for clients age 60 and above if the Guardian's caseload permits. Consideration should first be given to any appropriate relatives of the client.

Mental Health Commitments

Emergency Involuntary Hospitalization (Mental Health)

If an officer authorized to make arrests in the state, a licensed physician, a psychologist or a professional designated by the commissioner of mental health has reason to believe that a person is subject to detention because of the person's mental illness or serious emotional disturbance that poses an "IMMEDIATE substantial likelihood of serious harm," as defined in 33-6-501, to himself or others, then the officer, physician, psychologist, or designated professional can take the person into custody and detain the person without a civil order or warrant for immediate examination to obtain certification of need for care and treatment. T.C.A. §§ 33-6-401 and 402

Substantial Likelihood of Serious Harm — T.C.A. § 33-6-501

The standard of "substantial likelihood of serious harm," which is necessary for detention of the person for examination and for involuntary commitment, means:

IF AND ONLY IF

- A person has threatened or attempted suicide or to inflict serious bodily harm on the person, OR
- The person has threatened or attempted homicide or other violent behavior, OR
- The person has placed others in reasonable fear of violent behavior and serious physical harm to them, OR
- The person is unable to avoid severe impairment or injury from specific risks, AND
- There is a substantial likelihood that the harm will occur unless the person is placed under involuntary treatment, THEN
- The person poses a "substantial likelihood of serious harm" under this title.

Process

- Contact the local Mental Health Crisis Team or attempt to get the client to the hospital. APS staff must not transport the individual if the situation would place staff in danger.
- If law enforcement is involved, advise them to use the crisis team for evaluation.
- Contact family or close friends (if available) to advise them of the client's need for assistance and solicit their help.

A list is attached (Appendix E) but in Shelby County, Midtown Mental Health Center operates the crisis services for the entire county; in Davidson County, contact the Mental Health Cooperative; in Knox County, contact Overlook Center. In all other counties, contact the mental health center which customarily serves the area. Crisis teams can provide certification for emergency hospitalization, but may provide appropriate alternatives such as respite care or coordination of other appropriate mental health services.

Local law enforcement, if involved, should be advised to use the crisis team for evaluation. If a crisis team exists in an area, the law enforcement agency is not authorized to transport to a regional mental health institute for involuntary hospitalization without the involvement of a crisis team.

Additionally, a regional mental health institute is not authorized to admit on an emergency basis without the involvement of the crisis team. 33-6-104 33-6-105 and 33-6-106(b)

If a crisis team cannot examine the person within two (2) hours of the request to examine the person, then a licensed physician or a licensed psychologist with health service provider designation may examine the person and may provide one of the certificates needed for admission and evaluation if the physician or psychologist, in consultation with a member of a crisis response service designated by the commissioner to serve the county, determines that all available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.

If the licensed physician, psychologist, or other designated professional determines that the individual qualifies for admission, then the sheriff or other transportation agent can transport the individual to the hospital or treatment resource.

Examination at the Hospital or Treatment Resource

Once taken to the hospital or treatment resource, the physician, psychologist, or other designated professional performs another examination to complete a certificate of need for emergency diagnosis, evaluation and treatment. The examination must determine whether –

- The person is mentally ill or seriously emotionally disturbed, AND
- The person poses a substantial likelihood of serious harm because of the mental illness or serious emotional disturbance, AND
- The person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
- All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person. 33-6-404

If the examination does not demonstrate the person meets the requirements for admission, the person must be released.

If admitted, the General Sessions judge where the hospital or treatment resource is located must be notified immediately. The judge decides whether the individual should be immediately released or held for diagnosis, evaluation and treatment for not more than five (5) days, excluding weekends and holidays. If the court finds probable cause to hold the person for possible admission to a mental health facility, the court may order the person held for five (5) days from the date of the order for evaluation. 33-6-413

The chief officer of the mental health facility must file with the court, by the time of the probable cause hearing, certificates of need for care and treatment from two (2) licensed physicians or one (1) licensed physician and a psychologist qualified under § 33-6-427(a), certifying that the defendant satisfies the requirements of § 33-6-502(1)-(4), and that, if involuntary treatment is not continued, the defendant's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the defendant would be again admissible under § 33-6-403, and showing the factual foundation for the conclusions on each item of the certificates. See, 33-6-421.

If, after the hearing is waived or is completed and the court has completed its consideration of the evidence, including the certificates of the examining professionals, and any other information relevant to the mental condition of the defendant, the court finds:

(1) Probable cause to believe that the defendant is subject to care and treatment under § 33-6-502; and

(2) That, if involuntary treatment is not continued the defendant's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the defendant would be again admissible under § 33-6-403,

The court may order the defendant held for care and treatment pending a hearing under the judicial commitment law for involuntary hospitalizations for not more than fifteen (15) days after the probable cause hearing unless a judicial commitment complaint is filed under T.C.A. 33-6-502, within the fifteen (15) days.

If the court does not make these findings, the person must be released.

Non-Emergency Judicial Commitment Requirements - 33-6-502 and 503

Following any emergency hospitalization or for any mental health commitment proceedings that do not begin with an emergency hospitalization, a person who is seriously mentally ill and poses a substantial likelihood of harm to him or herself or to others can be judicially committed to a mental health resource:

IF AND ONLY IF

- A person has a mental illness or serious emotional disturbance, AND
- The person poses a substantial likelihood of serious harm because of the mental illness or serious emotional disturbance, AND
- The person needs care, training, or treatment because of the mental illness or serious emotional disturbance, AND
- All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person,

THEN

- The person may be judicially committed to involuntary care and treatment in a hospital or treatment resource in proceedings conducted in conformity with chapter 3, part 6, of title 33.

Certificates Certifying the Need for Judicial Commitment

In order to have the person hospitalized for treatment for their mental illness, two (2) licensed physicians, or one (1) licensed physician and one (1) licensed psychologist qualified as provided in § 33-6-427(a), must file in the commitment proceeding certificates of need for care and treatment certifying that the defendant satisfies the requirements of § 33-6-502(1)-(4) and showing the factual foundation for the conclusions on each item. 33-6-503

If the person has refused to be examined, then, based upon a sworn statement to that effect, if the court finds probable cause to believe the person is subject to involuntary care and treatment, the court may order that the person be taken into custody by a law enforcement officer for an examination.

Authority of non-physicians to perform examinations for admissions - 33-6-427

(a) If a person is a licensed psychologist designated as a health service provider by the board of healing arts and is actively practicing as such, the person may take any action authorized and perform any duty imposed on a physician by §§ 33-6-401--33-6-406.

(b) The commissioner may designate a person to take any action authorized and perform any duty imposed on a physician by §§ 33-6-401--33-6-406 to the extent the duties are within the scope of practice of the profession in which the person is licensed or certified, if the person:

(1) Is a qualified mental health professional under § 33-1-101;

(2) Is licensed or certified to practice in the state if required for the discipline; and

(3) Satisfactorily completes a training program approved and provided by the department on emergency commitment criteria and procedures.

Persons Authorized to file Complaint - 33-6-504

The Department of Human Services is authorized to file a complaint for judicial commitment for mental health treatment pursuant to T.C.A. 33-6-504 which states:

> The parent, legal guardian, legal custodian, conservator, spouse, or a responsible relative of the person alleged to be in need of care and treatment, a licensed physician, a licensed psychologist who meets the requirements of § 33-6-427(a), a health or ***public welfare officer [i.e., authorized DHS representative],*** an officer authorized to make arrests in the state, or the chief officer of a facility that the person is in, may file a complaint to require involuntary care and treatment of a person with mental illness or serious emotional disturbance under this part.

Commitment to a State Facility

If the Tennessee Department of Mental Health and the Department of Intellectual and Developmental Disabilities has designated a licensed state facility as having available suitable accommodations, the court shall commit the defendant to the state facility, and the defendant shall be placed in the custody of the commissioner. 33-6-505 and 33-6-509

NOTE: T.C.A. § 71-6-113 of the Adult Protection Act

When the department of human services is unable to find a resource for any person in need of protective services who, because of mental or physical illness, mental retardation or developmental disabilities, is in need of specialized care or medical treatment, the departments of mental health, intellectual and developmental disabilities, and health, or their successor agencies, shall, based upon available resources, give priority to the person for appropriate placement or treatment if the person is eligible for placement.

Discharge to outpatient treatment - 33-6-602

If, on the basis of a review of the person's history before and during hospitalization, the hospital staff concludes that:

- the person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission,
- the person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under § 33-6-501 unless treatment is continued,
- the person is likely to participate in outpatient treatment if legally obligated,
- the person is not likely to participate in outpatient treatment unless legally obligated to do so, and
- mandatory outpatient treatment is a suitable less drastic alternative to commitment, **then**
- the person shall be eligible for discharge subject to the obligation to participate in any medically appropriate outpatient treatment, including, but not limited to, psychotherapy, medication, or day treatment, under a plan approved by the releasing facility and the outpatient qualified mental health professional.

Discharge of the Person from an Involuntary Commitment

At the point that the person is determined to no longer need hospitalization, the chief officer of the facility will notify the court, and if a hearing is not set within 15 days, the person will be released by the chief officer. If a hearing is held, the court must find by clear unequivocal and convincing evidence that the person is not eligible for discharge. If it finds otherwise, then the person will be released from involuntary commitment. See T.C.A. §§ 33-6-701 – 708.

Domestic Abuse and Order of Protections - Legal Practice Guide -Appendix G

The Spousal Abuse / Domestic Violence Act went into effect July 1984 and several amendments to the Act have expanded the options available under the Act. In 1995, the Act's name was changed to the "Domestic Abuse Act" (DAA).

The client age eighteen (18) and above or the emancipated person under age eighteen (18) who has suffered, or is threatened with, abuse by a present or former household member may benefit from an order of protection. See T.C.A. §§ 36-3-601 et seq.

The definition of abuse in the Domestic Abuse Act (DAA) is broader in scope than the definition of abuse in the Adult Protection Act. Abuse under the DAA is defined as:

> Inflicting, or attempting to inflict, physical injury on a client or minor by other than accidental means, placing a client or minor in fear of physical harm, physical restraint, malicious damage to the personal property of the abused party, including inflicting, or attempting to inflict, physical injury on any animal owned, possessed, leased, kept, or held by a client or minor, or placing a client or minor in fear of physical harm to any animal owned, possessed, leased, kept, or held by the client or minor.

Abuse in the DAA is not based on the client's vulnerability as in the APS law and also includes the malicious damage to the property of the adult, as well as non-accidental injury to the adult.

An Order of Protection may be used at any point in a case when a client is abused or threatened with abuse by a present or former household member. A family or household member as defined in the DAA refers to spouses, persons living as spouses, persons related by blood or marriage, and **other persons jointly residing in the same dwelling unit**, who are eighteen (18) years of age or older. The definition of family or household member is broad in scope and includes the majority of persons with whom an abused client may reside.

What Is an Order of Protection?

An order of protection is an order granted for a fixed period of time, not to exceed one (1) year, to protect a client from abuse. This order is granted by a court with jurisdiction over domestic relations matters. The order may include, but is not limited to:

- Directing the abuser to refrain from abusing or threatening to abuse the client.
- Granting to the client possession of the residence or household by evicting the abuser, by restoring possessions to the client, or both.

- Directing the abuser to provide suitable alternate housing for the client when the abuser is the sole owner or lessee of the residence or household.
- Awarding financial support to the client when the abuser and the client are legally married.
- Prohibiting the abuser from stalking the client.
- Prohibiting the abuser from telephoning, contacting, or otherwise communicating with the client.

When a protection order is in effect, a law enforcement officer is empowered to arrest the abuser without a warrant under specific conditions. (T.C.A. § 36-3-611) The provision for prompt arrests without a warrant provides added protection for the client who is in great fear and danger.

Making the Decision to Use the Adult Protection Act and/or the Domestic Abuse Act (DAA)

Some protective services clients may benefit by a referral to the court to file a petition under the Domestic Abuse Act.

Examples of case situations in which clients may benefit from the Act include the following:

- Cases in which a client's family member or other individual residing in the client's home has abused and/or threatened the client with abuse;
- Cases in which a client is abused and/or threatened with abuse while residing in the home of a family member or other individual; and
- Cases in which an abused client will need financial support from the person who has abused and/or threatened him / her with abuse, and who has the duty to provide support to the abused client.

While the aforementioned situations may be viewed as fairly routine, consideration should also be given to more unusual situations in which we may use the Domestic Abuse Act in adult protective services cases, such as a situation in which the Department has alleged and provided sufficient proof to the court that a client lacks the capacity to consent to protective services, and the court has authorized the Department to provide protective services on behalf of the client. The Department may then consider petitioning the court as "next friend" using the Domestic Abuse Act to request an order of protection for the client who has been abused by a family or household member.

This case situation is described to allow for additional consideration of using the DAA in conjunction with the APS laws to provide additional protection to clients who have been abused or threatened with abuse by a family or household member. It is expected that the Domestic Abuse Act will seldom be used in this manner.

The Adult Protection Act (T.C.A. § 71-6-104) gives the Department the legal options to seek restraining orders and injunctions which can be enforced by contempt proceedings, just as in the Domestic Abuse Act. The legal options available under the Adult Protection Act should be used when they will provide the client with all the protection needed. If the client cannot be fully and adequately protected through the Adult Protection Act, then APS may consider using the two laws together. Also, there are some protections and provisions under the Domestic Abuse Act which are not available under the Adult Protection Act, such as those listed in T.C.A. § 36-3-606. The protection required by some clients may be more readily available under the Domestic Abuse Act.

When there is a question regarding the decision to refer the client to the court with jurisdiction over domestic relations, to use the legal interventions of the Adult Protection Act, or to use both the Adult Protection Act and the Domestic Abuse Act, this decision should be made jointly by the counselor and the supervisor in consultation with the DHS attorney for the district.

Orders of Protection Filed by Relatives of the Adult.

In 2010, the legislature passed Public Chapter 898, which became effective on May 10, 2010 authorizing relatives of an adult to seek orders of protection in situations where the adult may be suffering from abuse, neglect or exploitation as defined in the Adult Protection Act.

A relative is defined under the Act as: spouse; child, including stepchild, adopted child or foster child; parents: including stepparents, adoptive parents or foster parents; siblings of the whole or half-blood; step-siblings, grandparents, grandchildren, of any degree, and aunts, uncles, nieces and nephews.

The Act adds a new section, T.C.A. § 71-6-124 to the Adult Protection Act setting forth the requirements for filing for a petition for an order of protection and the authority of the court to issue orders, including injunctive relief to protect the adult from A/N/E and to order the return of any funds that have been misappropriated.

The orders are effective for 120 days and can be extended if necessary.

Written notice of the filing of the petition for an order of protection and copies of the petition and the ex parte order of protection against the perpetrator, if any, shall be sent by certified mail, return receipt to the APS unit in the county office of Department in the county in which the petition is filed. This is so that the

Department can be made aware of allegation of A/N/E and, if necessary, investigates those. If an investigation is initiated, and if further action to provide protective services is warranted, the Department has the right to intervene in the order of protection proceeding, but shall not otherwise be required to initiate any legal action as a result of having received the notice of the filing of the petition for an order or protection.

The Department may, at any time, file a petition pursuant to § 71-6-107 for custody, or to provide protective services to the adult without assuming custody, if it determines that the adult who is the subject of a petition for an order of protection is in need of protective services.

Adult Protection Act Available to other Agencies

Except as provided below, enforcement of the Adult Protection Act is solely within the jurisdiction of Department staff.

Petitions Filed by a Non-Profit Agency (when DHS refuses to file)
T.C.A. 71-6-107(a)(7)

The law permits private non-profit agencies representing disabled adults to petition the court for a custody order pursuant to the Adult Protection Act if the Department refuses to exercise its authority under the Act.

The private non-profit agency must give notice to the Department of its intent to file a petition and must satisfy the same criteria for granting a custody order and must refrain from filing a petition until TDHS has refused to do so.

If an order authorizing the provision of protective services results, the department's responsibilities are the same as they would have been if the department had sought the order.

NOTE: If the court finds that an order authorizing protective services is not warranted, then the petitioning agency will be responsible for the cost of the court-appointed attorney for the client and the court costs.

Petitions Filed By Other State Agencies – T.C.A. § 71-6-103(k)

The law provides that other state agencies have the authority to petition the court under the Adult Protection Act when the following conditions exist:

- The referral of abuse, neglect or exploitation of an client who is a resident of a facility owned and operated by the other state agency has been investigated by APS, and the other state agency has not taken the necessary steps to protect the client, and

- A report of the APS investigation has been submitted to the commissioner of the state agency, along with any recommendations for needed services to enable the client to be protected.

NOTE: Allegations of abuse, neglect, and exploitation occurring in facilities operated directly by the Tennessee Department of Mental Health (TDMD) or the Department of Intellectual and Developmental Disabilities (DIDD) shall be investigated by TDMH or DIDD. Under the provisions of T.C.A. § 71-6-103(k), DHS will not investigate allegations of abuse, neglect or exploitation in those facilities.

Prohibitions On Use of the Adult Protection Act

The law prohibits the use of the Adult Protection Act as specified below:

- **Living Wills** - Legal intervention will not be sought to provide medical care for a terminally ill client who has executed an unrevoked living will when the provision of medical care would conflict with the terms of the living will.

- **Treatment by Spiritual Means** - The client who relies on or is receiving treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment shall not be considered to be abused or neglected.

- **Mental Health Commitments -** The APS law cannot be used to adjudicate a client as incompetent under the state mental health laws or to commit a client to a mental health institution. Placement requires a judicial commitment petition under the mental health laws - See above.

- **Developmental Centers -** The APS law cannot be used for involuntary placement in a developmental center operated by the Department of Intellectual and Developmental Disabilities even if involuntary protective services are needed to prevent imminent danger of irreparable physical or mental harm or death. Placement can only be accomplished through approval and cooperation with appropriate staff of DIDD to determine if client is eligible for placement.

Chapter 12
DOCUMENTATION OF APS CASES

Legal Authority

71-6-101

Purpose

It is essential that the case file accurately reflect what has transpired with a client who is receiving services from APS. The purpose of case recordings is to substantiate the counselor's actions and conclusions.

APS records are business records of the Department and thus must reflect true, accurate and unbiased information. The accurate and timely recording of facts regarding a case enables the submission of the case record as a business record in legal proceedings in the absence of the social counselor who observed facts regarding the case.

The records may also be the subject of a discovery preceding that precedes litigation, and the counselor may be questioned as to the accuracy of the record and the counselor's observations and descriptions of events. Any information obtained or observations made which are used in case planning and decision-making must be included in case recordings associated with the case file and must be recorded close in time to the occurrence of the events that are being described.

Policy- Practice Guide-Appendix H

Case Recordings

It is necessary for APS staff to document all activities conducted in an APS case. The manner in which activities are documented is called case recordings.

Case recordings must:

- Be relevant, reliable and written in clear and complete sentences;
- Not include slang language (unless that language is a direct quote and is pertinent to the investigation) or subjective / personal value judgments;
- Not use abbreviations and acronyms unless they are commonly understood and acceptable; and
- Not be handwritten.

Case Recording Format – Dictation

Each client's record must include a description of each contact made on the case. The descriptions provide a means to organize and analyze case information. All major case decisions must be supported by the dictation entries and/or assessment information. In the automated system certain required tasks are linked to the documentation in the case recordings. Those tasks are displayed and indicators must be selected by the counselor when those tasks have been completed and documented in the narrative of the case recording. Failure to complete and document the required tasks will result in not being able to move forward in the case or will prevent completion of the investigation and may impede legal actions to protect the client.

Components of Each Entry

Each entry must include:

- The full date of contact (day, month, year);
- The full name of person contacted and relationship to the client;
- The full name of the APS Counselor (or other DHS employee) making the contact ;
- The type of contact, for example: phone, home visit, office visit, etc.;
- The full name of any person present during the contact and his / her relationship to the client;
- A summary of issues discussed, emphasizing relevant information pertaining to the presence of safety factors;
- Observations made by the APS Counselor that are relevant to the allegations and safety assessment.

Dictation entries must be electronic, with all narrative entered in the narrative text field of the case recording.

EXCEPTION - Numerous attempts to contact a person may be summarized in one entry. For example, "7/2/08 - The APS Counselor attempted to contact client by telephone four times today." (Also record the time of each attempted contact)

All contacts are to be documented as case recordings within five (5) working days of the contact.

Content of the Case Record

The complete APS case record consists of the electronic case information found in the automated system and the accompanying paper file (if one is necessary).

Case File

The case file includes all information that is entered into or generated by the automated system pertaining to a specific case. The information is maintained in the system beginning at intake and continuing throughout the life of the case.

Documents not generated by the automated system (such as e-mails, medical records, correspondence generated outside the automated system, reports provided by other agencies, photographs provided by an entity other than APS) will not automatically be included in the case file. In order to be included in the case file, these documents must be scanned and linked to the appropriate client record.

Scanned documents and all other external supporting case information related to a client's record that is not generated by the automated system should be maintained in a "paper file" that corresponds to the automated system record. The paper file should be identified by the automated system case identification number.

The contents of the electronic file should **NOT** be routinely printed and included as a part of the "paper file."

Chapter 13
CASE CLOSURE POLICY

Legal Authority – Tenn. Code Ann. § 71-6-101

Purpose

There is a need for a uniform process for closure of cases that end after investigation, after providing on-going services, or are closed without investigation. This policy pertains to investigative case closure and on-going services case closure only. Completion of investigation is found in the section on investigation.

Policy

APS shall formally close all investigative cases within 60 days of the assignment of the referral except for those cases that remain open for on-going services.

Prior to closing a case that has been open for on-going services, APS staff will ensure that the risks have been lowered or the safety level of the client has improved. In the event that the client refused services, the Counselor must document the client's capacity to refuse. In addition, all diligent efforts must have been completed and documented.

Investigative Case Closure

To properly close an APS investigation, all investigative tasks, safety assessments and outcome measurements and notifications must be completed within 60 days from the date the referral is assigned. If the referral was assigned from the priority register, the closure date is also 60 days or less from the date of assignment.

Case File Documentation Required for Investigative Case Closure

- Pre-Safety Assessment and Outcome Measurement tool
- Closure Safety Assessment and Outcome Measurement tool (assessment sheet, assessment scale and classification)
- Case Recordings to document the following:
    - Dates of contacts
    - Types of contacts
    - Names of persons contacted and relationships to the client

    - Issues discussed and client's responses

- All documentation gathered, *i.e.,* medical information, reports from service providers, completed Authorization for Services, Termination of Services, signed releases, photos, etc.

- Verification of notice to law enforcement and to the appropriate licensing authority if the person is receiving services from a facility required by law to be licensed or if the person alleged to have caused or permitted the harm to the adult is licensed under Title 63 of the Tennessee Code Annotated.

NOTE: This is a copy of all completed 1215s and is N/A if self neglect only

- Documentation that the client was notified of closure
- Notification of the referent regarding the outcome of the investigation
- Disposition of all allegations
- Determination of all perpetrators (unless self-neglect)
- Investigation classification as valid, invalid, or valid threat of harm
- Case Closure reason:
    - APS Close - Homemaker Only
    - Case Invalid
    - Client Died and Death IS Related to Abuse/Neglect
    - Client Died and Death NOT Related to Abuse/Neglect
    - Client Refuses Services after Due Diligence
    - Client Risk Reduced
    - Closing OGS to allow MERGE - This is security driven.
    - Moved to another State/Country
    - Unable to Locate Client after Due Diligence

Supervisor Approval Investigative Case Closure

The APS Social Counselor will obtain approval from the FS1 on the classification decision and the entire investigative file at closure. The FS1's approval will signify that:

- All documentation is complete and accurate
- All information and discussions have been reviewed
- The client has been notified of the decision
- The referent has been notified of the outcome of the investigation
- Appropriate law enforcement, or licensing authorities of facilities or of persons required to be licensed under Title 63 of the Tennessee Code Annotated, have been notified.

NOTE: This is a copy of all completed 1215s and is N/A if self neglect only

- All service providers or joint investigators have been notified, if applicable
- There are no outstanding APS court actions
- The client is not in an adult family home

Cases Closed Without Investigation

There may be times when it is necessary to close a case without an investigation.

- Client Died and Death IS Related to Abuse/Neglect
- Client Died and Death NOT Related to Abuse/Neglect
- Client Moved to Another State/Country
- Duplicate Referral - Previously Investigated
- Unable to Locate Client after Due Diligence
- Home Study Only
- Courtesy Interview for other state
- Auto-Assigned Instead of S/O - System Down Time - This is security driven.

Case File Documentation for Closure without Investigation

- Case Recordings to document the following:
    - Dates of contacts
    - Types of contacts
    - Names of persons contacted and relationships to the client

- Diligent Efforts
- Supervisor Approval

- Notification of the referent regarding the outcome of the investigation
- Appropriate law enforcement, or licensing authorities of facilities or of persons required to be licensed under Title 63 of the Tennessee Code Annotated, have been notified. :

NOTE: This is a copy of all completed 1215s and is N/A if self neglect only.

- Case Closure reason
  - Client Died and Death IS Related to Abuse/Neglect
  - Client Died and Death NOT Related to Abuse/Neglect
  - Client Moved to Another State/Country
  - Duplicate Referral - Previously Investigated
  - Unable to Locate Client after Due Diligence
  - Home Study Only
  - Courtesy Interview for other state
  - Auto-Assigned Instead of S/O - System Down Time - This is security driven.

Supervisor Approval for Closure without Investigation

The APS Social Counselor will obtain approval from the FS1 in order to close a case without investigation. The FS1's approval will signify that:

- All documentation is complete and accurate
- Diligent efforts have been completed and documented
- The referent has been notified regarding the outcome of the investigation
- Appropriate law enforcement, or licensing authorities of facilities or of persons required to be licensed under Title 63 of the Tennessee Code Annotated, have been notified.

NOTE: This is a copy of all completed 1215s and is N/A if self neglect only

- There are no outstanding APS court actions

- The client is not in an adult family home

On-going Services Case Closure

Case File Documentation for On-going Services Case Closure

- Closure Safety Assessment and Outcome Measurement tool
- Periodic Safety Assessment and Outcome Measurement tools if the case has remained opened for 6 month beyond the post investigation / ongoing services assessment
- Case Recordings to document the following:
    - Dates of contacts
    - Types of contacts
    - Names of persons contacted and relationships to the client
    - Issues discussed and client's responses
- All documentation gathered, *i.e.,* medical information, reports from service providers, completed 567 and 905 signed releases, photos, etc
- Face to face visit with the client occurring within the month of closure unless client is unable to be located or is deceased.
- Documentation that the client was notified of closure unless client is unable to be located or is deceased
- Closing Summary
- Case Closure reasons:
    - APS Close - Homemaker Only
    - Case Invalid
    - Client Died and Death IS Related to Abuse/Neglect
    - Client Died and Death NOT Related to Abuse/Neglect
    - Client Refuses Services after Due Diligence
    - Client Risk Reduced

- Closing OGS to allow MERGE - This is security driven.
- Moved to another State/Country
- Unable to Locate Client after Due Diligence

Supervisory Approval of On-going Service Case Closure

The APS Social Counselor will obtain approval from the FS1 for the on-going service case closure. The FS1's approval will signify that:

- All documentation is complete and accurate
- The reasons for closure are sustained by the documentation in the record
- All information and discussions have been reviewed
- The client has been notified of the decision
- All service providers have been notified, if applicable
- There are no outstanding APS court actions
- The client is not in an adult family home

Chapter 14
COURTESY INTERVIEWS/TRANSFER OF CASES

Request for Courtesy Interview

During an APS investigation and/or the provision of services, it may be necessary to interview individuals involved in a case who do not reside in, or may be absent from, the assigned counselor's area of coverage. The individuals(s) may be the alleged victim, alleged perpetrator, and/or family and friends as well as others who may have pertinent information. In these situations, APS staff may make a request to another APS unit to conduct the interview.

Prior to requesting a courtesy interview, APS staff should take into consideration the nature of the request. It may be more beneficial to the client and to the investigation for all interviews to be conducted by the same social counselor regardless of location. For instance, when there is a joint investigation with law enforcement or the licensing authority, the FS1 may decide that it is best for the interviews to be conducted by the same social counselor.

When a courtesy interview is needed from another unit in order to complete an investigation and/or for the provision of services, APS staff should follow the steps below:

- The social counselor to whom the referral is initially assigned will contact his / her FS1 in order to inform him / her of the situation. The social counselor should provide the FS1 with all pertinent information, *i.e*., names, addresses, safety concerns, etc.
- The requesting supervisor should contact the FS1 who will be receiving the case and make a request for the interview and provide all of the pertinent information.
- The FS1 who is receiving the case will assign the request to an appropriate social counselor. The interview will be conducted according to policy timeframes.
- After completing the requested interview, the social counselor will notify the original social counselor to whom the referral was initially assigned of any immediate concerns about services or safety. Documentation will be sent to his / her FS1 within 5 working days.
- The social counselor will provide documentation that the courtesy interview was entered into the automated system. An electronic notification will be sent to the assigned counselor for review.

Courtesy Visit

In some instances, the case may not need to be transferred but may need only a courtesy visit by a social counselor in the region to which the client has moved. If the APS case remains open, but the investigation has been completed, the assigned social counselor will submit a request to his / her FS1 for a courtesy visit. A courtesy visit conducted by a social counselor in the region to which the client has moved can determine whether or not the client needs continued APS services. If so, a case transfer will be conducted following the steps above. If the client appears to be in a safe and protective environment with no apparent service needs, the social counselor who has conducted the courtesy visit will enter the information in the automated system and provide documentation to his / her FS1, who will then forward that information to the requesting FS1.

Transfer of APS Cases

There may be times when a client moves from the area of one assigned counselor to another area of the State resulting in a need to transfer an active case to another APS unit or coverage area. This may occur during the investigation or while on-going services are being provided. Prior to transferring the case the following will occur:

- The social counselor to whom the referral is originally assigned will conduct interviews, request information, and complete all other tasks that can be completed.
- The original social counselor will complete the safety assessment and all other forms as much as possible with the information available.
- The original social counselor will discuss the transfer of the case with his / her FS1. If approved, the case will be reviewed by the FS1 prior to the transfer.
- The transferring FS1 will contact the FS1 who will be receiving the case to notify her / him of the impending transfer.
- The FS1 to whom the case is transferred will immediately assign the case to a new social counselor.
- In the event more information is needed, the FS1 receiving the case will contact the transferring FS1 to obtain the additional information.

Chapter 15
HEALTH AND SAFETY POLICY

Legal Authority – Tenn. Code Ann. §§ 71-6-101 et seq.

Purpose

In the performance of their duty, APS staff may from time to time find themselves in situations which pose some hazard to their safety and/or well-being, whether from communicable disease, a contaminated environment, criminal activities in the community, hostile and angry individuals or other hazardous conditions. Staff is never expected to jeopardize their life, health or safety. There are procedures and precautions which can help ensure the safety of APS staff as well as reduce risk to clients.

Policy

Physical Safety

While most individuals do not present a danger to the counselor, it is possible that staff will encounter clients and families who, in a crisis situation, become angry or hostile. However, the counselor can use strategies and techniques to help defuse anger and hostility and enhance the working relationship. See Practice Guide – Appendix J for further information. There can also be some instances in which individuals or situations may pose a physical threat. APS staff shall:

- Sign out on time sheets when leaving, indicating destinations. Let someone know the destination(s) and expected return time.
- Discuss with supervisors if there are concerns about the visit or problems are anticipated.
- Ensure his / her cell phone is available for emergency situations.
- Conclude the interview if the clients, or others in the home, make physical threats, becomes increasingly irate despite the counselor's efforts to diffuse the situation, or becomes physically intimidating.
- Not remain in a dangerous situation.
- File an Employee Safety Incident Report in the event that there is an incident related to a threatening situation. If the employee incurs an injury or health-related condition that requires medical care, compensation may be available. (Appendix J) See Practice Guide regarding Workman's

Compensation for procedures for filing claims for loss / damage to property or for medical care.

Encounters with the Production and Use of Methamphetamine During Investigations

The production and use of methamphetamine (meth) poses serious risks for the APS staff and clients. It is critical that steps are taken not only to protect clients, but to also ensure the safety of APS staff. If a referral is received in which there is reference to possible methamphetamine production or use, DO NOT go out on the referral without taking steps for your protection. Immediately contact your supervisor to plan for taking personal safety precautions and involving law enforcement. (Appendix J) See Practice Guide for more information.

Investigations in a Confirmed Methamphetamine Location - Practice Guide - Appendix J

If law enforcement (see working with law enforcement below) makes a referral about a location in which there is methamphetamine production and the referral meets APS criteria for investigation, the APS staff shall:

- Contact a supervisor for assistance in determining personal safety precautions;
- Remain in a safe location outside of the established perimeter until advised by law enforcement that it is safe to proceed;
- Not enter the location where methamphetamine was produced even if law enforcement makes a request in order to "obtain" evidence without a warrant;
- Interview and assess the client once clearance is given by law enforcement;
- Request that law enforcement do the following:
    - Describe the client's access to the drugs or paraphernalia if appropriate,
    - Document the ventilation in the home,
    - Document the potential for fire or explosion,
    - Detail all hazards found at the scene.

Investigations on Referrals that Allege Methamphetamine Production

The APS staff shall:

- Notify his / her supervisor;
- Notify local law enforcement and refrain from entering until law enforcement has confirmed the absence of any sign of methamphetamine production;
- Upon receipt of that confirmation, proceed with the investigation as outlined in the Investigations Policy;
- If law enforcement confirms the production of methamphetamine, APS shall follow the instructions outlined above.

Investigations Involving Suspected Methamphetamine Manufacturing

There may be situations in which, during a home visit, the APS staff see evidence and/or behaviors that cause concern that the location is a methamphetamine lab. (Appendix J) See Practice Guide for specific evidence of methamphetamine labs and behaviors of individuals who are using methamphetamine. It is important to note that methamphetamine production does not take place only in rural or residential locations. There are a growing number of instances in which these types of labs have been identified in motels, apartments and automobiles.

In situations where APS believe they are in the presence of someone suspected of using meth, the APS staff shall:

- Maintain a distance of at least 7 to 10 feet;
- Maintain a calm, low-pitched tone and slow pace in speech;
- Keep hands visible and avoid sudden movements;
- Engage the suspected user in talking. A meth user who falls silent may be extremely dangerous. Silence often means that paranoid thoughts have taken over and anyone present can become part of the user's paranoid delusions;
- Not sit down, and avoid any contact with surfaces in the area;

- Conclude the visit as quickly as possible and leave without arousing concern that drug use is suspected;

- Immediately wash your hands, shower and change clothes if possible;

- Not return to the site;

- Immediately inform their supervisor and law enforcement of concerns about the client in the home.

In situations where APS staff enter a location and see evidence of possible meth production, the APS staff shall:

- Leave the area immediately or as soon as possible if they suspect an operational or non-operational meth lab housed inside or outside of the residence. It is important to conclude the visit quickly, without causing concern to the individuals that APS suspects meth production. This is due to the potential paranoia and aggressive behavior of a user. By doing this it would also prevent the manufacturer from destroying the evidence.

- Observe and mentally note, if possible, specific chemicals which may be present so that observations can later be reported to medical and law enforcement personnel.

- Not use a sense of smell or touch to attempt to identify chemicals or unknown substances.

- Not walk through any area where the chemicals may have been spilled.

- Not do the following while in the home:

    - Touch, move, lift, carry, push or slide anything;

    - Shut off / turn on anything such as electrical machinery;

    - Turn lights or electrical appliances on or off, or use a land-line telephone or a cell phone unless absolutely necessary.

    - Open the refrigerator door;

    - Sit down.

- Notify law enforcement of the situation and concern for the client in order to coordinate the investigation.

- Notify his / her supervisor to advise of potential meth lab and to plan for the safety of the client.

APS Staff Exposure to Methamphetamine Lab

There may be situations in which the APS staff may have been exposed to a meth lab incidental to investigating an APS referral. If staff are exposed to the area or building where meth is being or has been manufactured, decontamination procedures must be followed as outlined below:

- Change clothes, including shoes, as soon as possible; do not wear contaminated clothing, including shoes, into the home or office if at all possible.

- Shower thoroughly with soap and hot water as soon as possible.

- Wash clothing in hot water and soap two times.

NOTE: Some sites warn against using bleach and dry cleaning. After washing clothes, run an empty cycle through the washing machine with water and bleach mixture.

- Clean the soles of the shoes with soap and water.

- Inform their supervisor and TBI, DEA or local law enforcement.

If the staff member experiences physical symptoms or suspects that he / she has been exposed, he / she shall:

- Seek medical attention immediately.

- Notify his / her supervisor who will advise him / her of the protocol regarding job related medical treatment process.

- Inform his / her doctor of the possible exposure and of any specific observations of chemicals and/or odors that may help the doctor to determine whether the symptoms are related to exposure and how to treat the condition.

- Complete a Safety Incident Report and file with appropriate DHS staff.

- File a Workman's Compensation claim if he / she believes that he / she is experiencing health problems from exposure to meth production.

Protocol for Client Health Conditions from Methamphetamine Exposure

In general, the physiological systems affected by exposure to chemicals and toxic substances will be the same for everyone. However, an ill, disabled or elderly adult may be more sensitive because of existing health problems such as COPD, asthma, emphysema, high blood pressure, confusion, slower activity of enzymes that metabolize medication and toxic compounds, etc. For these individuals, there may be increased concern about the effects on their red and white blood cell counts, kidney, liver and lung/respiratory function. (Appendix J) See Practice Guide for additional information.

Following is a protocol suggested by the Department of Health for assessing and responding to medical needs of the client found at a methamphetamine lab site. APS staff shall:

- Call 911 or other emergency number for a client with obvious injury or distress. Indications of medical emergency include skin rashes, respiratory or other distress. Be sure to advise any emergency medical personnel of the site's status as a meth lab and of the client having been exposed to chemicals.

- Encourage the client to go to the Doctor or ER to have an initial medical assessment be done no later than 24 hours of discovering the client at the meth lab site, or as soon as possible. This could also be done by EMT, PHN emergency room or other, such as a walk-in clinic.

- The initial assessment should include:

    - Blood pressure (adults with high blood pressure could be adversely affected by meth, ephedrine or pseudoephedrine),

    - Pulse,

    - Respiration,

    - Temperature.

- Not transport a client who is known to have been exposed to meth and who has not been decontaminated. The APS staff will ask law enforcement or EMS for assistance for transporting to the hospital.

- Encourage the client to leave his / her personal possessions at the lab site / home. Information necessary for obtaining medical treatment may be taken with him / her.

- Encourage the client to wash skin areas with soap and water, if he / she is able

- Obtain a baseline assessment at a medical facility within 24 hours of discovering the client at the site. The counselor will need to ensure that the physician is informed of the client's history of chemical exposure and as much detailed information as is available about types of chemicals, symptoms, initial medical findings, etc.

- Assist the client with obtaining a visit for follow-up care within 30 days of the baseline assessment to reevaluate the adult's health status and identify any latent symptoms or need for further treatment.

- Consult with the supervisor and legal if the client refuses a medical exam.

APS and Law Enforcement – Responding to Methamphetamine Labs

Because the production of methamphetamine is a dangerous and illegal activity, the APS counselor who has a case involving a meth lab site will need to coordinate with law enforcement as well. The following procedure has been recommended by the DEA and TBI:

- If the referral contains allegations of meth production, contact law enforcement before going out on the referral (see contacts below).

- If staff finds, without prior warning, that the home is a meth lab site, leave as promptly and unobtrusively as possible and immediately notify law enforcement as described below.

- Following are guidelines for law enforcement notification:

NOTE: If any law enforcement agency or individual requests that APS staff gain entry to premises to acquire evidence and/or remove evidence so that law enforcement does not need to obtain a search warrant, **DO NOT** agree to this request as it would: (1) be hazardous for the APS staff, (2) possibly would taint any evidence obtained making it inadmissible as evidence in the event of prosecution and (3) expose the counselor to possible civil rights liability.

    - APS should notify local law enforcement (police department, sheriff's department, etc.) unless there is reason to directly notify the TBI or DEA. Most counselors will have a working relationship with a representative of local law enforcement and may have some experience with their capabilities.

    - Local law enforcement in areas in which there is a high volume of methamphetamine manufacturing will have an established protocol for

notifying and working with the TBI and DEA. Ultimately, the DEA is responsible for arranging hazardous materials (HazMat) cleanup of the site.

- If local law enforcement does not have a protocol for meth lab response or is not able to respond promptly to help the APS counselor or seems unsure of how to respond, APS staff can directly contact the TBI or DEA.

- The TBI will be able to coordinate their investigation with the DEA as needed.

Contagious Diseases

It is important to note that it is not uncommon for the APS population to be residing in situations which may be conducive to contracting serious contagious diseases.

Some examples would be staph infection, methicillin-resistant Staphylococcus aureus (MRSA), bacterial meningitis, Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Clostridium Difficile Infectious Diarrhea (C-DIF) and Tuberculosis (TB). It is critical for APS staff, when known, to not place themselves at risk for these illnesses for the purpose of an investigation.

For the purpose of staff safety, the Health Department should be contacted to determine the risks and safety factors for staff prior to contact with the infected individual.

There will be occasions when APS staff is called upon to investigate referrals involving individuals suffering from contagious diseases. After conferring with the Health Department and determining that contact is appropriate, APS staff shall take the following precautions against infection:

- Wear disposable gloves during contact with blood or other body fluids that could possibly contain blood, such as urine, feces or vomit.

- Wear disposable gloves when staff may have contact with the infected person's open sores, cuts or other breaks in the skin.

- Wear disposable gloves to cover any breaks in the skin such as sores or cuts on own hands.

- Ensure that cuts, sores or breaks on staff's own skin are covered with bandages in order to prevent exposure.

- Wash hands and other parts of the body thoroughly immediately after contact with blood or other body fluids,

- Avoid handling or contact with needles or other sharp instruments which may be contaminated with blood or fluids from an infected person.

- Wash hands before handling food for preparation or before handling anything that will go in the mouth.

- Wash hands after using the bathroom, changing diapers or handling anything that may have been contaminated with fecal material.

- Wear medically approved face mask and gloves (Universal Precautions) if recommended by the Health Department during contact with the client.

If an exposure occurs:

- Wash needle sticks and cuts thoroughly with soap and water.
- Flush the nose, mouth or skin with water.
- Irrigate eyes with clean water.
- Immediately contact the supervisor to inform him / her of the exposure.
- Follow up with procedures for filing an incident report and seeking medical care via Workman's Compensation section below.

Workman's Compensation- See Practice Guide and Tennessee Treasury Website regarding Workman's Comp.

There may be times when APS staff, despite reasonable precautions, are exposed to communicable disease, other health hazard or incur injury to self or damage to or loss of property while in the performance of the job. In such situations the staff member may be eligible for compensation for medical expenses or for property loss / damage. If this situation occurs, the APS staff shall:

- Immediately inform the APS supervisor of any injury, health concerns, property loss or damage, etc.

- Contact Sedgwick James Claims Management Service at 1-800-526-2305 to obtain the name of the closest preferred medical provider in the area.

Go to the hospital or emergency room if the need for medical care is urgent and requires immediate medical treatment and then contact Sedgwick James at the first opportunity before incurring any further medical costs.

- Complete a Safety Incident Report.

- Contact DHS Human Resources if there is a need for possible compensation for loss of or damage to property.

- Contact the Health Department to notify of exposure to contagious diseases.

- The supervisor should immediately notify the appropriate person in DHS Human Resources who is responsible for Workman's Comp.

If the incident involves an automobile accident either in a state car or personal vehicle, the above steps also apply. In addition to the items mentioned above, the staff member must also:

- Explore appropriate and necessary emergency medical care for the client (if transporting a client) and for him / herself.

- Not admit or acknowledge fault or in any way accept responsibility.

- Secure and obtain a police report. A copy of the police report should be attached to the incident report.

- Complete an Accident Report RDA 1178 (TR-0231) and Worker's Compensation claim along with a copy of the police report and submit to DHS State Office Human Resources c/o Workman's Compensation.

Physical Assault of APS Staff during the Course of Employment

The Department has taken the position for several years that if a staff member is assaulted, he / she may, on his / her own volition, seek criminal charges against the assailant. If an employee is assaulted they must file an incident report. http://www.intranet.state.tn.us/dhs/forms/hs-2802.doc

Staff should know that, while the Department may agree in the abstract that the filing of the criminal charges by an individual who has been assaulted is justified in a given case, the individual is not filing the charges in his / her official capacity as an employee of the State of Tennessee. He / she is filing only as Jane / John Doe, private citizen, not as "Jane / John Doe, Social Counselor, TDHS."

Accordingly, should the individual be subject to a civil action by the alleged assailant as a result of any such charges, the State will more than likely not agree to provide legal representation or pay a judgment against him / her since the action is private and not within the scope of his / her employment. For this reason, staff should proceed with care and be very sure of the facts when filing a warrant. It is a good idea to discuss this with the District Attorney's Office before proceeding with filing any criminal charges.

DHS legal staff will not advise a staff member to file criminal charges in a specific incident even if the incident upon which the charges would be based arises out of his / her employment. The Department's attorneys can, however, provide information about the law and the legal process involving criminal actions in order to inform staff what actions constitute a crime, but this is not to be construed by program staff as legal advice since the Department's attorneys cannot provide advice involving legal actions that are not directly associated with Department programs.

Staff should know, however, that the District Attorney has discretion regarding whether or not to prosecute a case, and the DA may decide not to prosecute a technical violation of the law if the harm from the alleged assault is minor.

Staff should also know that DHS legal staff would not provide representation in criminal court or prosecute the case. The DA's office will represent the State, and indirectly, the social counselor as a crime victim.

Of course, if a staff member is injured on the job by an assailant, he / she should file a worker's compensation claim and may also have a cause of civil action against the individual, for which independent legal advice should be sought.

Chapter 16

NOTIFICATIONS POLICY

Legal Authority

T.C.A. § 71-6-103(d)(1), T.C.A. § 71-6-103(d)(2)

Purpose

During the course of an investigation, the APS law requires that certain notifications be made to other agencies. The purpose of this notification is to provide the necessary information to all agencies that need to be involved in order to provide protection to vulnerable adults. Notification can be made through the Form 1215, or in addition by telephone.

In addition, there will be times when a Notification of Death is submitted within the automated system. This notification is submitted to the HSPS when appropriate for a determination as to whether or not a Special Case Review is in order.

Policy

The Form 1215 must be completed on all but Self-Neglect:

- Be submitted on all referrals accepted for investigation by the designated staff no later than 2 working days from the acceptance of the referral.
- Be submitted by the investigative supervisor or his / her designee on all referrals screened out no later than 2 working days from the date of accepted for screen outs.
- Be submitted on all referrals deferred to the Priority Register no later than 2 working days from the date of acceptance for the Priority Register by the investigative supervisor.
- Be mailed, emailed or faxed to the appropriate agency.
- Be submitted to all agencies which require notification.
- Identify the agency(s) to which it was submitted.
- Be maintained in the record.
- Not identify the referent; however, the referent can be named as a witness if needed as long as it does not identify them as having made the referral.

Notifying Law Enforcement

When a referral **alleging abuse, neglect or exploitation of an adult by another person or persons** is received, APS is required to make a report to law enforcement. The report will be made to either the local sheriff or police department depending on the jurisdiction. Reports will be made to law enforcement when the referral includes an allegation which involves an adult client being harmed by another person, regardless of whether the call is accepted for investigation or screened out. The harm may be in either of two forms: a) commission of acts against the adult, *i.e.*, physical abuse; or b) omission of services needed by an adult who is left in the care of another person, *i.e.*, caretaker denies the adult needed food.

Notification of Law Enforcement will:

- Be made by using the 1215 which includes the following information:
    - Name, address and age of the alleged victim,
    - Allegation made regarding the alleged victim,
    - The alleged perpetrator's name, address and relationship to the alleged victim.
- Be made by telephone no later than 3 days to the designated law enforcement agency by the investigative supervisor or his / her designee if the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has been alleged as a result of abuse / neglect or exploitation. The 1215 will be submitted as outlined above subsequent to the call.

NOTE: If a copy of the referral is provided to law enforcement, the reporter's name and identifying information must be removed.

Notification to the Tennessee Bureau of Investigation (TBI)

Referrals which allege abuse, neglect or exploitation which does meet specific criteria specified below should be reported to the Tennessee Bureau of Investigation (TBI), **as well as** to local law enforcement. Reports should be made to the TBI agent who is responsible for the Social Counselor's coverage area. If the name of the agent is unknown, contact the TBI in the coverage area for this information. There may be circumstances in which the initial referral did not meet the criteria for TBI involvement; however, during the course of the investigation, the Social Counselor uncovers information which does. In those instances a report should be made to the TBI.

Notification to the TBI will:

- Be made by using the 1215 which includes the following information, to the extent known:
    - Alleged victim's name, address, phone number, date of birth and social security number;
    - Alleged perpetrator's name, address, phone number, date of birth and social security number;
    - Allegations, including: location of incident (bathroom, bedroom, hallway, closet, etc.); names and contact information for witnesses; description of physical evidence; brief synopsis of allegation.
- Be made by telephone immediately to the TBI by the investigative supervisor or his / her designee if the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has been alleged as a result of abuse / neglect or exploitation. The 1215 will be submitted as outlined above subsequent to the call.
- Be made when a referral meets the following criteria:
    - Abuse, neglect or exploitation occurred in a Medicaid-funded facility (example: nursing homes, institutions), or
    - The alleged incident(s) occurred in a Board and Care Facility **regardless** of whether payment is made from **Medicaid**; but the resident / patient is a TennCare recipient. Board and Care Facility include residential settings such as assisted living residences, residential homes, etc.
    - Alleged perpetrator provides care in client's home and is getting paid with Tenncare/Medicaid monies. (i.e. CHOICES Program)
    - The referral contains at least one of the following:
        - Physical evidence (body fluids, visible trauma, weapons, etc.), an eye witness, or a pending medical report which may document physical or sexual abuse.
        - Allegations of abuse or neglect which placed the adult in a potentially life-threatening situation, or which involve serious bodily injury, death or any type of sexual assault.

- An allegation of verbal abuse which caused the adult to reasonably fear imminent bodily injury.

Exception: Patient-to patient abuse will be reported **only** when there is an allegation or implication by the referral source that the abuse was related to neglect by the facility staff.

- Be made if the counselor and supervisor feel the report warrants TBI evaluation for possible investigation even if the referral does not strictly adhere to the above criteria.

NOTE: As with other reports to law enforcement, the name of the referent is not given verbally or in writing. When the referral is made by the Tennessee Department of Health, Health Care Facilities, **the fact that the report came from HCF <u>may</u> be shared with TBI,** although the **name of the person** who made the report is **not** shared.

Notification to the Licensing Authority

Notify the appropriate licensing authority if the referral concerns an alleged victim who is a resident of, or at the time of any alleged harm, is receiving services from a facility that is required by law to be licensed, or the person alleged to have caused or permitted the harm is licensed under title 63. Some reports may require multiple notifications including the licensing board for the person and the facility.

Notification to Licensing Authority will:

- Be made using the 1215 which includes, to the extent known:
    - Name, address and age of the alleged victim;
    - Name of the licensed facility, included under the address;
    - Allegation(s) made regarding the alleged victim; and
    - The alleged perpetrator's name, address and relationship to alleged victim.
- Be made by telephone immediately to the licensing agency by the investigative supervisor or his / her designee if the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has been alleged as a result of abuse / neglect or exploitation. The 1215 will be submitted as outlined above subsequent to the call.

- Be made if referrals are received that involve residents or patients of licensed facilities, clients receiving services from licensed facilities, or if the alleged person causing or permitting harm is licensed by the health licensing laws.

    - Persons licensed under title 63 are reported to the Tennessee Department of Health (TDOH) – Health Related Boards. Appendix E for the list of professions licensed under title 63 and where the 1215 should be sent.

    - Nursing Homes are reported to the Tennessee Department of Health (TDOH) – Centralized Intake Unit. Appendix E

    - Homes for the Aged and Residential Homes for the Aged are reported to the Tennessee Department of Health (TDOH). Appendix E

    - Hospitals, Residential Hospice and Assisted-Care Living Facilities are reported to the Tennessee Department of Health (TDOH). Appendix E

    - Home Care Organizations (Home Health, Hospice, Home Medical Equipment) are reported to the Tennessee Department of Health (TDOH). Appendix E

    - Residential facilities for mental health are reported to the Tennessee Department of Mental Health and the Tennessee Department of Intellectual and Developmental Disabilities (TDMH / DIDD) – Regional Offices.

    - ICF-MR facilities are reported to the Tennessee Department of Health (TDOH) – Regional Offices. Appendix E

NOTE: They are certified by TDOH but licensed by TDMH

Open Arms (Knoxville, Chattanooga, and Nashville)
Mur-Ci Homes
Palmyra/New Dawn
Salem Villages
Stones River

Notification to the Department of Intellectual and Developmental Disabilities (DIDD)

When the Department accepts a referral alleging abuse, neglect, or exploitation of an adult by a paid caretaker contracted with DIDD or employed by an agency contracted with DIDD, APS will notify DIDD of such allegations. DIDD also wants to be notified of client to client abuse.

Notification to DIDD will:

- Be made using the 1215 which includes, to the extent known:
    - Name, address and age of the alleged victim;
    - Name of the licensed facility, included under the address;
    - Allegation(s) made regarding the alleged victim; and
    - The alleged perpetrator's name, address and relationship.
- Be made by telephone immediately to DIDD by the investigative supervisor or his / her designee if the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has been alleged as a result of abuse / neglect or exploitation. The 1215 will be submitted as outlined above subsequent to the call.

The Form 1215 is used for notifying DIDD. The Form 1215 should be faxed, emailed, or mailed to:

Director of Investigations
Department of Intellectual and Developmental Disabilities
State of Tennessee
15th Floor, Andrew Jackson Bldg.
500 Deaderick Street
Nashville, TN 37243
615-253-2896
615-532-9940 (fax)

Notification to the District Ombudsman

When a referral alleging abuse, neglect, or exploitation of an adult in a long term care facility is accepted, APS will notify the local ombudsman of such allegations. Long term care facilities include nursing homes, assisted living facilities, boarding homes, group homes, and Homes for the Aged. This includes allegations of abuse, neglect, and exploitation by facility staff and non-facility staff such as family members. APS should also notify the local ombudsman of referrals that may be screened out by APS when there is a pending eviction for non-payment.

Notifications to the District Ombudsman will:

- Be made using the 1215 which includes, to the extent known:

- Name, address and age of the alleged victim;
- Name of the licensed facility, included under the address;
- Allegation(s) made regarding the alleged victim; and
- The alleged perpetrator's name, address and relationship.

- Be made by telephone immediately by the investigative supervisor or his / her designee if the person making the referral indicates that physical or sexual abuse or life endangering neglect is occurring or death has been alleged as a result of abuse / neglect or exploitation. The 1215 will be submitted as outlined above subsequent to the call.

The Automated System Notice of Death

APS may receive notification that a current or former client has died. When the information is received, the following will occur:

- The APS staff person who received the information will conduct a search in the automated system to locate the correct client;
- The APS staff person will then complete a Notice of Death;
- The Program Supervisor, when appropriate, upon receiving the Notice of Death, will review the information to determine if a Special Case Review needs to occur; and
- The Program Supervisor will convene a Special Case Review, if appropriate.

Chapter 17
INTERSTATE POLICY

Legal Authority – T.C.A. §§ 71-6-101, et seq.

Purpose

While there is no APS Interstate Compact Agreement, there are situations in which APS would respond to requests from APS in other states as a matter of courtesy. This cooperation is related to the potential need for similar assistance from other states on similar case situations.

Policy

TN APS Request for Assistance to Other States

While working with an adult in a protective services situation, it may be necessary to make contact with a family member or other resource in another state. As there is no Interstate Compact Agreement, contact may be made in the following manner:

- Contact the family member directly
- Contact the appropriate agency directly

Home Studies

There may be an occasion when APS in another state is conducting an investigation or working on a case in which there is a need to have a home study conducted on an individual who resides in Tennessee. In those instances APS will do the following;

- Visit the home, observe and document observations
- Interview the individuals residing in the home and document observations
- Obtain information about the individual's plan to provide daily care, supervision (if necessary) and any special medical or mental health care if appropriate
- Provide a report that contains no recommendation, but only the factual information and observations by the Social Counselor

Courtesy Interview

There may be instances in which APS in another state is investigating a referral or working on a case and in this context TN APS is requested to conduct an

interview of an individual who resides in Tennessee. This interview is called a courtesy interview. In those instances, APS will:

- Interview the individual to obtain the information requested
- Provide a report that contains no recommendation, but only the information obtained by the Social Counselor

Court Orders Received from another State

In the event that APS receives a court order from another state ordering Tennessee APS to conduct a home study, courtesy interview, placement or a recommendation the following steps must be taken:

- Notify the supervisor
- Provide order to Legal and follow their directions

Chapter 18
SPECIAL CASE REVIEW POLICY

Legal Authority – T.C.A. §§ 71-6-101, et seq.

Purpose

Each unit will have access to a team which will conduct special reviews of specific adult protective services cases. The teams will be required to review certain types of case situations and may review other types. The teams will be convened on an as needed basis to be determined by the HSPS. The criteria for special case reviews are as follows:

Policy

Circumstances that Require Convening a Special Review Team:

- An open case in which there is a client fatality that is alleged to be the result of abuse, neglect, exploitation, or self neglect.
- A case that is the basis of a civil or criminal suit against DHS or DHS staff.
- An open case in which the client is repeatedly hospitalized due to abuse or neglect during the life of the referral.
- An open case in which a client is repeatedly hospitalized due to self-neglecting behaviors during the life of the referral.

Optional Circumstances for Convening of a Special Review Team:

- An open case that contains an order to consent to services to prevent irreparable mental or physical harm or death and there is a death of the client. These may be custody cases or non-custodial protective services orders.
- A closed case in which there is a client fatality that is related to abuse, neglect, or self neglect, and the case was in an open status sometime during the 90 days prior to the death, if the death becomes known to the Department.
- An open case in which a client is hospitalized due to self neglecting behaviors.
- A closed case in which there is an incident of physical injury / illness (requiring hospitalization) of a client due to self neglect, abuse or neglect and there was an open case sometime during the 90 days prior to an incident, if the incident becomes known to the Department.

- A case that has received intensive or extensive media coverage.
- A complex case, at the request of APS management staff. (For example, repeated referrals for repeated hospitalizations, regardless of whether the case was open or closed at the time of new referrals.)

Special Case Review Team Composition

- The APS Program Supervisor, Field Supervisor and Social Counselor who were involved in the case, and
- An APS Supervisor and Social Counselor who were not involved in the case nor in the line of supervision, and
- A representative of the local APS Multi-Disciplinary Team.
- In some instances, where deemed appropriate, State Office staff may be included.

Special Case Review Process

Notification

- The APS Program Supervisor and the APS Director must be notified when an incident occurs that warrants a Special Case Review – whether mandatory or discretionary.
- The notification shall take place on the same day that the information is learned and may be conveyed by telephone, fax or email.
- Within a maximum of 5 working days of becoming aware of an incident which may merit a Special Case Review, the APS Counselor will have their case current in the automated system and any additional information related to the case must be submitted to the Supervisor.

Review

- The APS Program Supervisor will review the file to determine the need to convene the Special Review Team.
- If appropriate, the Team shall be convened within 30 calendar days of the APS Program Supervisor's decision that the case needs to be reviewed.
- The APS Program Supervisor shall prepare a report of the team's findings as specified in the Special Review Report.
- All case files and other confidential material will be returned to the FS1 at the conclusion of the review

Special Review Report

Within 15 working days of the review by the Special Review Team, the APS Program Supervisor will provide a report, using the *Special Case Review Summary Report* (link), of the team's findings to the APS Director, Field Supervisor and Counselor responsible for the case.

The report should include findings assessing the following:

- Casework effectiveness
- Policy Compliance
- Recommendations for future agency practice or training
- Policy or legal recommendations
- Corrective action, if indicated

Chapter 19
MULTI-DISCIPLINARY TEAM POLICY

Legal Authority – T.C.A. § 9-8-307(h)

Purpose

The purpose of the Adult Protective Services Multidisciplinary Case Consultation Team (M-Team) is to assist the Department in providing effective services for those clients who have been determined to be in need of protection.

Policy

Composition of Team

Composition of each team will vary depending on the resources and needs within the District. Suggested team members include:

- Physician (needs alternate / back-up)
- Psychiatrist / Psychologist (needs alternate / back-up)
- Nurse
- Pharmacist
- Gerontologist
- Social Worker (Hospital, Mental Health, etc.)
- Ombudsman (District level)
- Member of Clergy
- Representative of Aging Network
- Representative of Vocational Rehabilitation
- Representative of Developmental Disability
- Nursing Home Administrator
- Law Enforcement
- Attorney

Availability of Teams

- A sufficient number of teams are to be established in each district to ensure the availability of a team for staff in each county.
- A team is not required in every county.
- Teams should be available within a reasonable distance from each county.

Appointment of Team Members- Practice Guide - Appendix L

- All team members receive an appointment letter from the Program Supervisor.
- Appointments are for one year and begin with the date noted on the appointment letter.
- Reappointments may occur at the completion of the year's service.
- Each member will complete the second page of the Volunteer Enrollment Form HS-1262.
- Submit the Registration of Volunteers section of the Volunteer Enrollment Form HS-1262 to DHS Human Resources.
- Each member will sign a Confidentiality Agreement

Confidentiality

- The name of the referent will not be shared with the team.
- Should the M-Team have recommendations that involve another agency, APS will provide that recommendation to the other agency.

Team Meetings

- Shall be scheduled on a regular basis.
- May be called as emergency meetings.
- May vary in length depending on the agenda.
- Are attended by team members, DHS staff (counselor, supervisor / coordinator).
- May be attended by other professionals involved with the adult who have pertinent information to share. Such individuals should not be present during the discussion of the case.

DHS Coordinator Responsibilities

- Provides or arranges for orientation of team members.
- Schedules meetings, sets agendas and presides over meetings.
- Schedules cases for review
- Notifies counselors and supervisors of the meetings.
- Records recommendations in the automated system.

- Acts as liaison between department staff and team members.
- Disseminates information to team members.
- Coordinates communication between the team members and department staff.

Record Keeping

The Coordinator for the team is responsible for maintaining a record of the ongoing activities of the team including:

- Copies of appointment letters for each team member;
- Copies of second page of HS-1262 - Volunteer Enrollment form for each team member;
- Copies of forms used by the team;
- Information regarding orientation for team members;
- Records / minutes for each meeting, including: date, time, and place of each meeting; persons present and, if there are persons present who are not team members or DHS staff presenting a case, a statement of the reason for this person's attendance;
- Cases reviewed;
- Counselors / supervisors presenting cases;
- Team recommendations and follow-up or feedback requested; and
- Copies of the completed referral form, completed recommendation or feedback form.

Note: the team log may suffice for the major part of the record keeping process, if they are completed and filed together for each meeting.

Forms / Letters

- Appointment Letter
- Confidentiality Agreement
- Referral Form
- Team Recommendation Form
- Feedback on Team Recommendation Form
- HS-1262, Volunteer Enrollment Form

Tennessee Department of Human Services

ADULT PROTECTIVE SERVICES

PRACTICE GUIDE

April 2011

ADULT PROTECTIVE SERVICES
Intake Practice Guide
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Appendix A
INTAKE PRACTICE GUIDE

Intake Interview

The purpose of the intake interview is to obtain sufficient information to establish the alleged victim's eligibility / need for the protective services investigation and to determine the assignment status based on risk to the alleged victim. The intake process is critical to the provision of protective services.

Enough information should be obtained to enable the counselor to evaluate the concerns of the referent. The information obtained will indicate how emergent the needs of the alleged victim may be which will affect how the referral is assigned.

Effective and thorough intake can assure that alleged victims in need of protective services receive needed services as soon as possible based on the allegations. Since the intake interview is the beginning of the casework / service delivery process, it has important casework consequences. Intake may also have important legal implications. Although a small percentage of the cases referred ultimately require legal intervention, the information gathered at intake may be useful evidence if court action is necessary.

These services for alleged victims must be provided without regard to race, color, or national origin.

> No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. (Title VI of the Civil Rights Act of 1964, as codified in 42 U.S.C.2000d.)

To ensure accurate and thorough communication and to comply with Title VI Civil Rights protections, the intake counselor must be alert to recognize any barriers that may arise due to impairments and/or limited English proficiency (LEP). To assist with communication, APS has access to foreign language interpreter services, TTY telephone services for the deaf / hard of hearing and/or other community services that provide interpreter / translation services. Investigation Policy - Chapter 6

Referrals to APS

The Department accepts and investigates referrals which allege that an adult who, because of mental or physical dysfunction or advanced age is unable to protect himself / herself, is being abused, neglected, or financially exploited or is at imminent risk of abuse, neglect or financial exploitation and has no available individuals to assist them. TCA 71-6-101.

Referrals come to the Department by telephone, in writing, by fax, by electronic methods, by postal service or by people making referrals in person. In the event that a written referral is not legible or the contents cannot be clearly discerned due to handwriting, effects of fax or any other reason, intake should contact the referral source to obtain clarification of the allegations.

In those situations in which such an unclear written / faxed report is received from Health Care Facilities Intake Unit, APS intake should contact Tennessee Department of Health-Health Care Facilities Centralized Intake Unit for clarification of the report. (1-877-287-0010, M-F 7:00 a.m. to 7:00 p.m.)

Self Referrals

Requests for services may come in many forms and the words "neglect, abuse, or exploitation" may not always be used by the person asking for services. The key is for counselors to be keenly aware of the meaning of what the alleged victim is saying and be able to interpret the needs they have described. The fact that a person requests services for him / herself does not mean that he / she is able to protect him / herself. Such a request by an alleged victim is actually a self-referral for protective services when the described condition falls within the definition of an alleged victim being unable to protect him / her self from being harmed or threatened with harm.

An alleged victim may request help because he / she:

- Is being subjected to abuse, neglect and/or exploitation by a caretaker or other person and the alleged victim may believe that they are unable to prevent the abuse. The alleged victim may fear that they will not be able to survive if the caretaker puts him / her out of the home or leaves.
- Is unable to consistently obtain necessities for daily living and/or perform essential tasks needed for health and safety, and requests our assistance. Careful questioning may reveal a significant level of risk which warrants protective services.

Conditions of Need

In Adult Protective Services, there are **essentially two conditions which must be met** before an adult can be accepted for a protective services investigation.

The alleged victim **must be unable to protect his / her own interests, *and* he / she must be at risk in that he / she is threatened with or is being abused, neglected or exploited by a caretaker. However, if sexual abuse or self-neglect of an adult is the basis of the report, such circumstances do not have to be caused by a "caretaker."**

If the adult is unable to protect him / her self but is not at risk, then the adult does not need protective services. (Example: The adult with severe retardation who is being adequately cared for by family members.) If the adult is at risk but able to protect him / herself, then the adult does not need protective services. (Example: The normally functioning adult who is beaten by a neighbor.)

Before a protective services investigation and assessment can be initiated, there must be allegations that these two conditions exist.

Adults who are Unable to Protect Their Own Interests

The adult's inability to protect his / her own interests must be based on his / her mental dysfunction, physical dysfunction or frailty due to advanced age. A person eighteen (18) years of age or older who is mentally impaired but still competent shall be deemed to be a person with mental dysfunction for the purposes of this the APS law.

a. **Mental Dysfunction** - Mental functioning which is significantly impaired or deficient making the adult unable to recognize the consequences of his / her behavior, unable to identify his / her needs and take the steps necessary to see that those needs are met, or unable to perceive relevant facts and reach a **rational** decision based on those facts.

   The alleged victim may be lacking in experiences or abilities to comprehend the risks of his / her actions; or, be lacking in abilities to make choices or follow through with appropriate actions that ensure protection, without receiving guidance, support and direction.

   This category may include those who are emotionally disturbed, developmentally delayed or have an intellectual disability, as well as those whose abilities to protect themselves are significantly impaired by extreme stress, isolation, confinement or illness, etc.

   This category does not include those alleged victims who function normally and are simply in need of information regarding other services and, to our knowledge, are able to follow through with obtaining needed services, **but simply use poor judgment.**

   An alleged victim may be considered incapable in one phase of his / her life while able to function adequately in other areas. Denial of an obvious problem should lead one to question an alleged victim's mental functioning in that area.

   NOTE: Having a mental illness alone does NOT meet the criteria for mental dysfunction, it must be alleged that the mental illness prevents the adult from protecting him / herself.

b. **Physical Dysfunction** – The alleged victim is physically unable to protect him / herself from neglect, hazardous or abusive situations and/or to take care of basic needs such as personal hygiene (bathing), necessary shopping (food), bill paying (utilities), food preparation, or obtaining required medical care.

   NOTE: Having a physical disability alone does NOT meet the criteria for physical dysfunction, it must be alleged that the physical dysfunction prevents the adult from protecting him / herself.

c. **Advanced Age** – An alleged victim who is 60 years of age or older and is unable to manage his / her own resources, carry out the activities of daily living or protect him / herself from neglect, hazardous or abusive situations.

   These alleged victims may be mentally or physically dysfunctional; suffer from personal losses which make adapting to cultural and societal complexities difficult; have grown frail, feeble and/or isolated; or may be victims of other conditions which may be associated with advanced age making them in need of protective services.

Adults Who Are at Risk of Being Abused, Neglected or Exploited

Adults who are in such a situation that the conditions described above are imminent, believed to be impending or believed to be likely to occur if there is no intervention by DHS are considered to be "at risk of being abused, neglected, or exploited." Intake counselors must be able to explain and document their reasons for believing that the alleged victim is at risk.

Several examples of the alleged victim who may be in a situation which warrants careful evaluation of whether or not harm is impending include the alleged victim:

- Who has shown an inability to follow through with doctor's appointments, medication and counseling sessions and/or other plans or activities to reduce or alleviate conditions that may pose serious risk to health and/or safety without supervision;
- Whose health is deteriorating;
- Who appears unable to comprehend results of decisions;
- Whose history includes allegations of previous sexual or physical victimization;
- Whose history includes allegations of A/N/E by a person who is or who will be acting as a caretaker;

- Whose living conditions will not be safe when the seasons change (winter);
- Who lives in the home of another person who resents the burden of caring for the client;
- Who repeatedly has been without food or utilities;
- Who is living in extreme filth including clothes, linen, dishes, etc.;
- Who appears to have adequate income but is having trouble meeting his / her basic needs for food, clothing, shelter, and utilities; or
- Who suffers from a mental illness that impacts the ability to care for him / herself (*i.e.,* not eating, not taking life-sustaining medications, etc.).

Guidelines for Obtaining Needed Information at Intake

Cue Question Guide

The following information is important to obtain in the intake process as well as during the investigation if at all possible. Please be mindful as to how to guide the interview in order to obtain this information. Questions may need to be framed differently in order to obtain the information when speaking with referents. Some of the information may be gathered naturally during the course of the intake interview and some may require specific questioning. Intake is the first portal of entry for clients into APS. Information gathered at this time is crucial in determining the need for investigation and intervention. It is important for APS intake staff to recognize that they do not simply answer the phone – **they actually conduct investigative interviews.** Gathering of critical and complete information will not only ensure that appropriate clients are served, but will also help intake staff feel comfortable in screening out those referrals that are not appropriate.

Referent Information:

If the referent has not requested to remain anonymous, intake staff needs to collect as much of the following as the referent is willing to provide:

- Referent name
- Address
- Phone numbers (work, home, cell)
- Specific relationship to the alleged victim

- Email address

Verify with referent correct spellings of names and addresses.

Alleged Victim Information

- Alleged victim's name
- DOB
- SSN
- Address (including county) and directions to the home
- E-mail address
- Phone number (home, work, cell)
- Insurance Information
- Gender and race
- Ethnicity

Verify with the referent the correct spelling of names and addresses.

- Income amount and source (important for financial exploitation referrals).
- Current living arrangement for the alleged victim if different from the home address - Example: hospital, private home, nursing home, assisted living facility.
- Be sure to document name and address of current location.
- Describe in detail the alleged victim's impairment.
- How are they unable to protect themselves?
- Where did the alleged incident take place?
- Describe those specific ADLs that the alleged victim is unable to perform. Do not list ADLs that client can perform independently.
- Does the alleged victim require physical aids such as walker, wheelchair, cane, etc.?

- If the alleged victim is employed, document the place of employment, work hours and phone number.

- Do you know of any other agencies or persons who assist the alleged victim? If so, do you know the names, addresses, and/or agency and phone number of those involved? What services do they provide?

- Does the alleged victim suffer from any medical / mental diagnoses or conditions (acute or chronic)? If yes, what is the name of the condition or the diagnosis?

- Who is the primary care physician?

- Does the alleged victim have prescribed medications? If yes, what are they and for what diagnoses are they prescribed? Name of pharmacy?

Caretaker information (if applicable)

Alleged Caretaker Information

- Name

- DOB

- SS#

- Address

- E-mail address

- Phone numbers of caretaker? (work, home, cell)
  List all if there is more than one.

- What services does the caretaker provide?

- Verify with reporter the correct spelling of names and addresses.

- If the caretaker is employed, what is the place of employment, work hours and phone number of caretaker?

- What is the caretaker's relationship to alleged victim?

- Does the caretaker reside in the home with the alleged victim?

- If caretaker does not reside in the home, how often does he / she provide care? For example: daily, weekly, monthly, etc.

- Does the caretaker provide care for any other vulnerable adult?

If there is a professional caretaker, ask these additional questions:

- Where is the caretaker employed?

- Is the caretaker licensed?

- Is the employer licensed and by whom?

- Is anyone else conducting an investigation and, if so, who?

- Is the agency of employment aware of these allegations and have they taken any action to protect the alleged victim?

- Is the caretaker currently employed (working)?

Alleged Perpetrator (if applicable)

Alleged Perpetrator information

- Name

- DOB

- SS#

- Address

- E-mail address

- Phone (work, cell, home)

- Verify with the reporter the spelling of names and addresses.

- Employment history

- What is the relationship of the alleged perpetrator to the alleged victim?

- How often does the alleged perpetrator have contact with the alleged victim?

- If the alleged perpetrator is not a caretaker, does the caretaker know about the abuse and is he / she taking any steps to protect the alleged victim?

- Will the alleged perpetrator have contact with any other vulnerable adult?

Allegations of Harm:

- What prompted your call today?

- What are your concerns?

Depending on what information the referent provides, the following questions may need to be asked, based on the allegations:

If the allegation is physical abuse:

1. What does the injury look like to you (size, shape, color, number of injuries and location on the body)?

2. When did you see the injury? *If caller has not seen the injury, ask for the name and contact information for the person who has.*

   NOTE*: Contact the person who has seen the injury and ask these questions.*

3. How did the injury occur?

4. How do you know about the injury?

5. Have you seen injuries in the past and, if so, how many times? What did they look like? Where were they located?

6. Was the alleged victim able to say what happened? If so, what was the explanation given by the alleged victim?

7. If there is a caretaker, what is the caretaker's explanation?

8. What is the alleged perpetrator's explanation about the injury?

9. Were there any witnesses to the incident? If so, who are they and what is their contact information?

   NOTE*: Contact the witness to verify the information.* Did a medical professional see the alleged victim? If so, what is the name and phone number of the doctor?

10. What did the doctor say about the injury?

NOTE: *Contact the doctor to gather additional information that could impact the screening decision.*

11. If the referent is a medical professional, is the injury, in the opinion of the referent, consistent with the explanation?

Neglect

NOTE: This would also include self-neglect if there is no caretaker.

Depending on what type of neglect is being reported, consider asking the following questions:

Environmental Neglect

1. Describe in detail those conditions in the living environment that constitute health and safety hazards. (If I walked in the home, what would I see?)

2. Have these conditions been reported to the local health department?

3. How does the referent know these conditions exist? If referent did not observe these conditions but received information second hand from someone who did, attempt to obtain contact information on that individual, but do not refuse to take the referral because the referent does not have "first hand" information.

NOTE: *Contact the actual witness for specific information*.

4. When was the last time you saw the alleged victim or the home?

5. How long have these conditions existed?

6. Do you know why the conditions exist?

7. Is the alleged victim able to fix the conditions or able to obtain assistance in fixing the conditions? If so, why haven't they?

8. Does the alleged victim live alone? If not, who else lives in the home?

9. Are there any health or safety hazards for APS staff?

Nutritional Neglect

1. Describe the physical condition of the alleged victim.

2. What makes you believe the alleged victim is not getting enough food?

3. Does the alleged victim appear to be malnourished or dehydrated?

4. Does the alleged victim live alone or is there someone else who would be responsible for the nutritional needs?

5. When do you think the alleged victim was last fed and what was the meal?

6. When does the alleged victim report having last eaten?

7. When was the last time you saw the alleged victim?

8. Have you been in the home? If so, what food supplies have you seen? If the reporter says no food, ask for clarification (*i.e*., no canned goods, etc.)

9. Have you noticed a weight loss or gain in the alleged victim and, if so, how much?

10. Is the alleged victim able to prepare or obtain meals?

11. Is the alleged victim able to feed self? Is the alleged victim refusing to eat?

12. Has there been a recent decline in the alleged victim's appetite or recent rapid weight loss?

13. Has a medical professional seen the alleged victim and, if so, what is the contact information?

14. Do you know what the doctor's opinion is about the care of this individual?

NOTE*: Contact the doctor's office and obtain additional information which could impact the screening decision.*

15. If the referent is a medical professional, what is the medical diagnosis? What will happen if the condition continues?

16. Do you know of any medical conditions from which the alleged victim suffers that might contribute to the nutritional condition?

<u>Medical Neglect</u>

1. What are the alleged victim's medical issues?

2. What symptoms are you seeing?

3. What are your concerns?

4. Does the alleged victim live alone? Is the alleged victim failing to meet his / her own medical needs?

5. Who else has information about this issue and what is the contact information?

NOTE*: Contact this individual to obtain more information that would impact the screening decision.*

6. Is the alleged victim on prescribed medication? If yes, what is the name of the medication?

7. For what condition is the medication prescribed?

8. Is the alleged victim taking the prescribed medication appropriately?

9. Does the alleged victim take any OTC medication?

10. Is there a caretaker? Is this person aware of the medical condition? If so, what does the caretaker say about the situation?

11. What does the alleged victim say about needing medical attention?

12. When did the alleged victim last see a medical professional?

13. What does the alleged victim say about why medical attention has not been sought?

14. If the alleged victim has not seen a medical professional, what does the caretaker say about why medical attention has not been sought?

15. If the alleged victim has a medical professional, what is the name and phone number?

NOTE*: Contact this individual to obtain more information that would impact the screening decision.*

16. Does the alleged victim appear to understand his / her medical condition?

17. Does the alleged victim appear to understand the consequences of failing to seek medical attention?

18. Does the alleged victim have a POA for healthcare or other legally responsible party who assists in making decisions for medical care? If yes, who is it?

19. For a referent who is a medical professional, ask:

    - What is the medical diagnosis?

    - What will happen, and how soon, if the medical condition is not treated?

    - The medical professional to send / fax pertinent medical information.

20. For a medical professional who calls requesting APS to obtain a court order for medical procedures, ask:

    - Is the alleged victim able to make a medical decision?

    - Is there an identified legally responsible party to make decisions? If yes, who is it?

    - Has the professional considered using the Department of Health Rule 1200-8-1-.13(16)(h) providing for a physician to make a health care decision for a hospitalized individual who is without a surrogate or other authorized persons to consent to medical care? **(Staff should not attempt to suggest to the medical professional that this procedure be used during intake as a substitute for potential legal action to provide these services under the Adult Protection Act. Staff should consult with supervisory and legal staff about the use of this process established by the Department of Health's rules.)**

    - Is there a current psychological evaluation for the alleged victim? If yes, ask the medical professional to send / fax a copy of the evaluation.

Sexual Abuse

1. What makes you think the alleged victim has been sexually abused?

2. When was the last time you saw the alleged victim and under what circumstances?

3. Have you seen any signs or behaviors that indicate sexual abuse and, if so, describe them?

4. If you have not seen the signs or behaviors, who has? What is the contact information?

NOTE*: Contact that individual for more information.*

5. Has the alleged victim told anyone about the sexual abuse? If so, when? Who did the alleged victim tell and what is the contact information?

6. What did the alleged victim say happened?

7. Do you know when (the date or approximate date) and where the sexual abuse occurred?

8. Is this the first time the sexual abuse occurred? If not, how long has it been going on?

9. If the caretaker is not the alleged perpetrator, does the caretaker know about the abuse? If so, what is the caretaker's plan for protection?

10. Where is the alleged victim now?

11. When does the alleged perpetrator have access to the alleged victim?

12. Does the alleged perpetrator have contact with other vulnerable adults?

13. Is the referent aware of the location of other vulnerable adults?

14. Does the alleged perpetrator know the abuse has been reported? If so, have the allegations been discussed with the alleged perpetrator?

15. What does the alleged perpetrator say about the allegations?

16. Has a medical professional seen the client for the sexual abuse concerns? If so, what is the contact information?

NOTE*: Contact them for more information that could impact your screening decision.*

17. Has anyone contacted law enforcement? *If yes, who has been assigned the case?*

***Additional questions to ask if the referent is a medical profe*ssional:**

1. Has a medical exam been conducted? If so, what are the findings?

2. If the alleged victim is verbal, is the alleged victim's statement consistent with findings?

3. Are the findings consistent with sexual abuse allegations?

4. Is law enforcement present? If not, have they been called and what is their response?

Substantial Threat of Harm—Note: this may also be self-neglect.

1. What are your concerns about the risk of harm to the alleged victim?

2. Describe the conditions or the behaviors of the caretaker or alleged victim that give you reason to believe harm may occur.

3. Has abuse occurred and, if so, where and when?

4. Are you concerned about the ability of the alleged victim to care for or protect him / herself and if so, why? What are the specific concerns?

5. Has the caretaker expressed concern about hurting or being able to provide care for the alleged victim? If yes, who heard those concerns and what is the contact information for that person(s)?

NOTE*: Contact this individual if it is someone other than the referent to obtain additional information.*

6. How much access does the alleged perpetrator have with the alleged victim or other vulnerable adults?

7. Is there a history of, or is there currently, domestic violence in the home? If yes, describe the incident(s), including what law enforcement agency was involved, if any.

8. Who has been involved in the domestic violence situations? If the alleged victim was not involved, how did the incident(s) impact the alleged victim?

9. Has the alleged perpetrator been indicated or convicted of violent crimes against a person? If so, where did that occur and what were the circumstances?

10. Are there weapons in the home? If so, where are they kept? Are the weapons a safety risk to the alleged victim? Are they a safety risk to the investigative counselor?

11. If the alleged perpetrator is not the caretaker, is the caretaker aware of the threat of harm? If so, is unsupervised contact allowed? What does the caretaker say about the potential threat of harm?

12. Has law enforcement been contacted? If yes, who has been assigned the case?

Additional questions to ask If there are allegations of manufacturing drugs:

1. Has law enforcement been notified and what was the response?

2. How is the manufacturing of drugs impacting the alleged victim?

3. How have you become aware of the manufacturing of drugs?

4. What types of drugs are being manufactured and by whom? If not being manufactured in the home, what is the proximity to the home?

5. When were they last made? Were you in the house?

6. When was the last time you were in the home?

7. Was the alleged victim present in the room / home? If not, where was the alleged victim? How do you know this information?

8. Where are the fumes being vented? Where are the chemicals being stored?

9. Does the alleged victim have easy access to the chemicals / drugs?

10. Does the alleged victim exhibit any symptoms of being exposed to the manufacturing? If so, what are the symptoms?

11. Has the alleged victim sought or been provided medical attention if he / she has been exposed to the manufacturing of these drugs? What hospital or doctor provided the medical attention?

12. If the referent is a medical professional, what is the diagnosis and what are the lasting effects of exposure.

Emotional Abuse

1. Describe specifically what the alleged perpetrator is doing or saying to the alleged victim.

2. Did you witness this conduct or did you hear this from someone else? If someone else is the witness, who is it and what is the contact information?

NOTE*: Contact this person for more information.*

3. How is this behavior impacting the alleged victim? Have you noticed a change in the alleged victim's behavior?

4. What specific signs or behaviors is the alleged victim exhibiting?

5. How do you think the alleged victim's behaviors are related to the caretaker's actions or inactions that are believed to be emotionally abusive?

6. What does the alleged victim say about the behavior / language of the alleged perpetrator?

7. Has the alleged victim expressed a desire to commit suicide? What specifically was said? Have the appropriate mental health agencies been contacted? If so, who was contacted and what was the response?

Financial Exploitation

1. What is the source of the alleged victim's income?

NOTE: If the source is NOT government funds, then it is not an APS referral, however, additional information may be needed for law enforcement.

2. What specifically causes you to suspect that financial exploitation has occurred or is occurring?

3. How is the money being used inappropriately and by whom?

4. Why do you believe this individual is a caretaker?

5. How does the alleged perpetrator account for the misuse of the money?

6. Are the alleged victim's basic needs, such as food, shelter, clothing, medical needs, etc. being met? If not, what specific bills are being left unpaid?

7. What does the alleged victim say about the misuse of the money, and when was the last time that you spoke with the alleged victim?

8. How do you know this information? If the information is from another source, what is that person's name and contact information?

NOTE*: Contact this person for more information.*

9. Do you have any documentation of the exploitation, *i.e*., bank statements, checks, unpaid bills, etc.?

10. How does the alleged perpetrator have access to the alleged victim's funds? For example, is there a POA, payee, conservator, etc. for the person?

11. Is anyone else aware of the exploitation? If yes, what is the contact information?

NOTE*: Contact this individual for more information.*

Intake Closure Cue Questions

1. Does the alleged victim, caretaker and/or the alleged perpetrator have any special needs or problems, such as:

    a. Difficulty communicating (*i.e*., language other than English, low communication skills, no communication skills, etc.)

    b. Mental illness

    c. Physically handicapping conditions

    d. Behavior problems, (*i.e*., extreme anger, volatile, bizarre or acting out behavior)

    e. Abuse of drugs or alcohol

2. If the report is assigned for investigation, are there any safety issues for the social counselor that we need to be aware of, such as: weapons, vicious dogs, physically aggressive behaviors, previous threats to law enforcement and/or APS?

Assurance to the Reporter

DHS staff may advise the person making the report that:

1. The reporter's name is confidential;
2. APS may make follow up contacts with the reporter;

3. The reporter is free from civil and criminal liability for reports made in good faith, even if the allegations are ultimately determined to be unfounded; and
4. In order to be advised of the outcome of the investigation, a name and phone number must be provided.

The above stated suggested questions to ask at intake are not to be used as a rigid interviewing guide. Flexibility is essential at intake, since each case situation is different. Because of these differences, every item included in the intake guide will not apply to every intake situation.

Appendix B
INVESTIGATION PRACTICE GUIDE

The investigative process consists of multiple activities which assist the Social Counselor with determining the validity of the allegations and ensuring the safety of the client. The primary issue during the investigation is the client's safety and well-being.

While prosecution of a perpetrator may be a desirable goal and the Department's policy is to notify law enforcement authorities and cooperate fully with any criminal investigation and prosecution of abuse, neglect, sexual abuse or exploitation of a perpetrator, it is not the foremost goal of APS. Protection and safety of the client are the primary goal of APS, and all avenues must be explored to successfully achieve that end.

During an investigation, there are 3 critical steps:

- Gathering information regarding the allegations in the referral by conducting interviews, observations, and records checks;
- Determining the outcome of the investigation and the safety level of the client from the information gathered by utilization of the Safety Assessment / Outcome Measurement and evaluating all the information gathered; and
- Making protection decisions during the investigation, such as
    - Did abuse / neglect / exploitation occur and, if yes, who is the perpetrator?
    - Is the client in danger or risk of harm? If so, does the client have capacity?
    - What is the safety level of the client?
    - If services are needed to protect the client, will the client accept them and, if not, does the client have capacity?

Investigative Strategy

Prior to initiating an investigation, it is helpful if the Social Counselor develops an investigation strategy. This does not have to be in the form of a formal written plan, but should be based on ideas that the Social Counselor develops from the referral. The investigative strategy is a fluid process and may change several times depending upon information obtained. Some questions to consider when developing an investigative strategy are:

- What is the nature of the allegation(s)?
- What other investigative agencies need to be notified or involved in this investigation?
- What APS policies apply to this type of investigation?
- What information is needed and who has the information?
- When would be the best time to interview the alleged victim and others involved in the investigation / case?
- Who should interview the individuals in the case? This could be especially important if it is a joint investigation with law enforcement.

In developing an investigative strategy, it is important to:

- Gather as much information about the client and the allegations as possible prior to responding;
- Determine the best time for an interview based on information contained in the referral; and
- Determine any special considerations that need to be taken into account during the interview:
    - Is the client hearing or sight impaired?
    - Are there any language barriers?
    - Are there cultural considerations?
    - How would the client's mental or physical disabilities impact the method of interview?

Interviewing the Alleged Victim

The purpose of the investigation is to substantiate or unsubstantiate the allegations stated in the referral and to identify other safety issues and service needs. Because sexual abuse is often difficult to talk about and is often not considered in association with impaired adults, the referral may not specifically identify abuse, neglect, or exploitation as the problem. The counselor, however, should be aware all types of abuse, neglect or exploitation are possible. Experts agree that it is highly unusual for only one type of abuse, neglect, or exploitation to be occurring and **every case should be screened for multi-faceted abuse, neglect, or exploitation.**

If the alleged perpetrator is the primary caretaker or someone who has regular access to the client, interviewing the client may have to be postponed until a time

when the alleged perpetrator is away from the home. A disclosure is unlikely if the client knows the alleged perpetrator is in the next room or is present when the interview takes place.

Whether the client is elderly or is disabled in some way, sexual abuse is emotionally and sometimes physically traumatizing, and the client needs a calm, non-judgmental, reassuring, supportive response from the counselor. Because sexual abuse is about the loss of control, it is especially important for the client to be given as many opportunities as possible to control the disclosure of his / her own abuse. For example:

- Let the client choose where the interview will take place;
- Interview the client alone;
- Always ask where the client would like for you to be seated;
- Address the client by Mr./ Mrs./ Ms. and his / her last name unless permission is given to do otherwise;
- Use language that is clear and on the client's own level, asking open ended questions and moving at the client's pace;
- Ask only one question at a time;
- Resist the urge to touch the client, even on the hand or the arm;
- Let the client know he / she has the right to refuse to answer all or any questions; and
- If taking notes during the interview, explain why.

Try to obtain a voluntary disclosure by asking focused questions, moving if necessary from the general to the specific. Ask clarifying questions. It is important to know as many details as possible about the abuse.

Use non-verbal means of communication, such as anatomically detailed dolls, anatomical drawings, and word or picture cards when the client has a language or speech impairment, is physically or mentally impaired or is too embarrassed to use the necessary words to describe what has happened.

Consider the possibility of both male and female offenders, as well as victims of both genders. Keep in mind that sexual abuse of an impaired adult has frequently occurred multiple times, perhaps by multiple perpetrators and do not regard any part of a disclosure as "confusion," "rambling," "hallucinating" or "embellishing" on the part of the victim.

Some very basic questions for the interview would be:

- What happened to you?

- What happened next?
- Who did this to you?
- How did it happen?
- Where did this happen?
- When did this happen?
- Who saw this happen?

Caretakers

The caretaker's role may be the result of an informal agreement, family relationships or life-long friendship. APS must engage the caretaker and they will usually be involved in reducing the risk to the client, unless they are the alleged perpetrator.

Caretakers who Consent

APS normally expects caretakers to work with the Department in seeking the best interests of the client. As long as the client or the caretaker consents to APS involvement with the client, APS staff is free to **enter any private premises where a client is alleged to be abused, neglected or exploited in order to investigate the need for protective services**. In cases in which the client agrees to accept protective services, and has the capacity to consent, the caretaker does not have the right to interfere. Generally, it is in the client's best interest for the cooperation of the caretaker to be gained. Such a person is usually in the best position to assist the client in improving the client's situation and seeing that his / her basic needs are met. When APS is able to examine the situation and the relationship of the client and the caretaker, it may be determined that many problems of neglect are brought on by lack of knowledge, lack of resources, and stress due to guilt over the client's condition, etc. If the problem can be identified, then APS may be able to make long-term improvements in the conditions which exist. There should be empathy for caretakers who are making an effort to "help out" in what are usually very difficult situations.

Caretakers who Refuse Consent- TCA 71-6-103 (f)

If the client or caretaker does not consent to the investigation, a search warrant may be issued upon showing of probable cause that an adult is being abused, neglected, or exploited. The search warrant will enable the Department to proceed with the investigation and, ultimately, help facilitate the provision of any needed services. If the client consents but the caretaker refuses to consent to the investigation, then the court may enter a decree enjoining the caretaker from interfering with the investigation.

NOTE: If a caretaker owns the property and tells APS to leave and does not allow the APS investigation, APS must leave and seek a search warrant through TDHS Legal.

Interviewing Collaterals / Witnesses

Collaterals and witnesses can often provide valuable information that is germane to the investigation. A witness is an individual who has observed the specific allegations occurring. A collateral is an individual who has obtained information about the allegations, even though they did not witness the incidents. They may provide a "missing link" in the investigation or be able to support or refute the statements of others. Prior to interviewing these individuals, APS should think through what information they already have and what information is still needed. It is important to explore the relationship between these individuals, the client, and the alleged perpetrator. When interviewing collaterals / witnesses APS should focus questions on a specific day, time or event, if possible. Critical to the investigation is distinguishing what these individuals have observed first hand from what they have heard about the situation from someone else, which may lead to another witness. Ask for details and clarify vague statements in order to obtain the most specific information as possible.

Some possible questions for these interviews are:

- What happened to the client?
- Where did it happen?
- When did it happen?
- What happened next?
- Who did this to the client?
- How did it happen?
- Who else may have seen this happen?

Interviewing Alleged Perpetrators

Unless the case is self neglect, there will be an alleged perpetrator (AP) although sometimes the identity of the perpetrator is unknown. In those instances the role of the Social Counselor is to carefully conduct an interview of the client (if the client is able to be interviewed) and interview any available witness and collaterals in an attempt to determine the identity of the alleged perpetrator.

It is important to consider the client's wishes and capacity in making the determination to interview the alleged perpetrator (AP), particularly if that individual is also the caretaker in the home. If the client has capacity and does not want APS to interview the AP, that preference should weigh into the

counselor's decision to interview the alleged perpetrator. If it is appropriate to interview the alleged perpetrator, he / she should be the last person the Social Counselor interviews. The Social Counselor should obtain information from everyone else involved in the case prior to interviewing the alleged perpetrator if at all possible.

However, if the alleged perpetrator is a paid caretaker, he / she must be interviewed, unless he / she refuses. This is important particularly if the allegations have been validated, and the Department intends to proceed with placing the name of the indicated perpetrator on the abuse registry.

Prior to interviewing the alleged perpetrator, the Social Counselor should:

- Review / assess the client's statement;
- Review / assess statements from collaterals and witnesses;
- Review other evidence gathered;
- Review the record;
- Develop an investigative strategy regarding the alleged perpetrator interview by:
    - Preparing for the interview by reviewing information obtained during the investigation,
    - Developing a minimum set of questions to assess the allegation of abuse / neglect / exploitation and the culpability of the alleged perpetrator, and
    - Setting the environment for a productive interview, *i.e.*, not interviewing the alleged perpetrator in front of the client.

When conducting interviews of an alleged perpetrator, it is important to:

- Use open ended questions;
- Obtain detailed and specific information;
- Highlight contradictions by:
    - Being alert,
    - Remaining neutral and patient,
    - Using follow up questions,
    - Pressing for clarification,

    - Being alert for partial admissions,
    - Expressing firm belief in client's allegations, if applicable, and
    - Persevering as this may be the only chance to interview the alleged perpetrator.
- Listen to not only what the alleged perpetrator says, but also to what they leave unspoken. For instance, if the individual is asked to describe his / her activities on the day in question, pay particular attention to gaps of time that are left out. It is important to follow up on those pieces of times; and
- Ask the individual to clarify particular details. For example, it is not uncommon for someone to make a statement like "I walked into the room and she fell." This type of non-specific statement should be a red flag for the APS staff. This is the opportunity to obtain some specificity about the incident.
- After obtaining the verbal statement from the alleged perpetrator, it is often helpful to ask him / her to provide a written statement that is dated and signed.

Some questions for the alleged perpetrator are:

- What happened to the client?
- What happened next?
- Where were you when it happened?
- Who did this to the client?
- Where did it happen?
- When did it happen?
- How did it happen?
- Why do you think that you are named as the perpetrator?

Special Considerations When Investigating Financial Exploitation

When investigating reports of exploitation, the following issues must be considered:

- Does the client have the mental / physical capacity to manage his / her own financial affairs?
- How are the client's resources being used?

- Are client's basic sustenance needs being met?
- Does another person write checks on the client's account?
- When did the alleged exploiter take control of the client's resources and under what circumstances?
- Determine whether the client is a willing participant in the exploitation. If yes, determine why the client is willing to be exploited.

Sexual Abuse

Consideration should be given to the client's circumstances in deciding the appropriate response time. Information regarding the client's situation, obtained prior to interviewing the client, may be beneficial. Contacting collaterals prior to contacting the client may be appropriate and useful. The safety and well-being of the client should be of foremost concern in the decision regarding the response time, but any delay in response time should be explained in the case recording. For example, if the client was alleged to have been sexually abused in a day placement, it would be more appropriate to interview that individual at home as opposed to the center.

Self-Neglect

Self neglect accounts for approximately half of all APS referrals, yet it is frequently unrecognized. It is important for APS staff to understand that self-neglect may, and quite often does, exist even when abuse / neglect / exploitation by a caretaker have been alleged.

Self-neglect involves an adult who is unable and/or unwilling to obtain for him / herself services needed to prevent physical or mental injury / illness. Self-neglect is the result of an adult's inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs." (This definition was adopted by the National Adult Protective Services Association (NAPSA) in October, 1990.)

Neglect and self-neglect may include failure to obtain / receive needed:

- Medical care for serious illnesses;
- Other care to prevent physical or mental injury / illness;
- Food; and/or
- Provide / maintain safe shelter.

The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his / her decisions, makes a conscious and voluntary decision to engage in acts that threaten his / her health or safety as a matter of personal choice.

Signs and symptoms of self-neglect include, but are not limited to:

- Dehydration, malnutrition, untreated or improperly attended medical conditions, and poor personal hygiene;
- Hazardous or unsafe living conditions / arrangements (e.g., improper wiring, no indoor plumbing, no heat, no running water);
- Unsanitary or unclean living quarters (e.g., animal / insect infestation, no functioning toilet, fecal / urine smell);
- Inappropriate and/or inadequate clothing, lack of the necessary medical aids (e.g., eyeglasses, hearing aids, dentures); and
- Grossly inadequate housing or homelessness.

Components of Neglect and Self-Neglect are defined below:

Physical or Mental Injury /Illness – Injuries / illnesses which result in conditions which are debilitating or, if not treated, would become debilitating; or conditions which would cause permanent disabilities; or conditions which would be considered terminal if not treated. Consider conditions which are not accepted as normal for most functioning adults (common cold or mild depression vs. kidney disease or suicidal tendencies).

Medical Neglect may include situations in which caretakers have failed to seek needed medical care for a client or situations in which the client has failed to obtain such care for him / herself. The needed medical care is believed to be of such a nature as to result in physical or mental injury / illness if such care is not provided. Medical care may include the services of physicians, nurses, in-home medical services, hospitalization, required medication, nursing home care, etc.

Inadequate food is failure to receive food necessary to prevent physical injury or to maintain life, including failure to receive appropriate food for persons with conditions requiring special diets (e.g., diabetics).

Inadequate shelter may be shelter which is not structurally safe; has rodent or other infestations which may result in serious health problems; or may not have a safe and accessible water supply, heat source or sewage disposal. Safe shelter for a person will depend on the limitations of an individual person; however, the person must be protected from the elements which would seriously endanger his / her health (rain / cold) and result in serious illness or debilitating conditions.

Clients do not have to have running water or central heat and air in their homes in order to be safe. Wood heat may be perfectly all right for one person but create a danger for another. A client who must rely on wood heat but is physically unable to chop or lift wood will have to have special arrangements made in order to ensure that he / she has heat when it is needed.

Inadequate clothing is the lack of clothing considered necessary to protect a person's health. It is generally expected that an adult needs clothing to provide protection from excessive cold. Inadequate clothing would be clothing that is insufficient or inappropriate for the weather.

Hoarding

Hoarding is an issue that is not uncommon to some APS clients. It is important that Social Counselor's understand that hoarding may be an indicator that the client may be unable to make clear decisions or that he / she is unable to control his / her thought or behavior processes. It may also be an indication of some psychological issues such as obsessive compulsive disorder (OCD), social isolation or depression.

Clients who are hoarders often save or gather items that other individuals may consider worthless. When entering these homes, the APS staff may find narrow walking space in the home due to the collection (to the excess) of trash, papers, and clutter in general. It is not uncommon for individuals who are hoarders to also collect animals. Not just one or 2 pets, but an excessive number of animals. This typically results in the client being unable to provide adequate care for the animals thus elevating his / her problems.

It is important for APS to be able to distinguish clutter in a home from hoarding. Clutter is defined by Webster's Dictionary as "to fill or cover with scattered or disordered things that impede movement or reduce effectiveness." Clutter is included in hoarding. However, hoarding takes clutter to the excess. Clients may be unable to throw away items such as trash, newspapers, magazines, etc. They may often keep used food containers. These items are often stacked on every item in the home, and, when there is no more room in the home, it may overflow into the yard, outbuildings and vehicles. He / she may believe there will be a need for the items in the future and often form attachments to the items to the point that he / she does not want anyone to touch or move them. Much time may be used in moving the items around in the home, but never throwing them away.

Capacity

APS begins with the premise that a client has the ability to make his / her own decisions. When a client does not have this capacity, provision of services can be a difficult undertaking for APS.

Below is information on this question that was obtained from a Tennessee Court of Appeals opinion:

In the Matter of the Conservatorship of Ellen P. Groves
No. M20000-00782-COA-R3-CV
November 8, 2000 Session

In the opinion, the court stated:

“Capacity is not an abstract, all or nothing proposition. It involves a person’s actual ability to engage in a particular activity. Accordingly, the concept of capacity is task-specific. A person may be incapacitated with regard to one task or activity while retaining capacity in other areas because the skill necessary in one situation may differ from those required in another.” The opinion cited a case that stated capacity is also situational and contextual.

The court went on to say that “[capacity] may be affected by many variables that constantly change over time. These variables include external factors such as the time of day, place, social setting, and support from relatives, friends and supportive agencies. It may also be affected by neurologic, psychiatric, or other medical conditions such as polypharmacy, and many of which are reversible with proper treatment. Finally, capacity is not necessarily static; it is fluid and can fluctuate from moment to moment. A change in surroundings may affect capacity, and a person’s capacity may improve with treatment, training, greater exposure to a particular type of situation, or simply the passage of time.

“In some cases, capacity encompasses two concepts - functional capacity and decision-making capacity. Functional capacity relates to a person’s ability to take care of oneself and one’s property. Decision-making capacity relates to one’s ability to make and communicate decisions with regard to caring for oneself and one’s property. The distinction between cognitive capacity and competence in actual performance is somewhat artificial because functional capacity depends, in part, on decision-making capacity. Functional capacity to care for oneself involves a person’s ability to perform basic daily activities. These activities commonly referred to as ADLs and IADLs, including personal hygiene, obtaining nourishment, mobility and addressing routine healthcare needs. An inquiry into functional capacity seeks/needs to ascertain whether a person has functional impairment that endangers physical health or safety by rendering the person unable, either wholly or partially, to care for him or herself. Emphasis should be placed on a person’s ability to carry out essential activities in his or her everyday environment, not in the laboratory, doctor’s office or courtroom. The examination should focus on behavior over time, not one or a few specific events whose prejudicial character may lead to a premature conclusion.

“Decision-making capacity involves a person’s ability (1) to take in and understand information, (2) to process the information in accordance with his or

her own personal values and goals, (3) to make a decision based on the information and (4) to communicate the decision. Requiring that decision to be tested against a person's own values and goals reflects the importance of determining a person's capacity in light of his or her own habitual standards of behaviors and values, rather than the standard and values of others. A person does not lack decision-making capacity merely because he or she does things that others either do not understand or find disagreeable. Foolish, unconventional, eccentric, or unusual choices do not, by themselves signal incapacity. However, choices that are based on deranged or delusional reasoning or irrational beliefs may signal decision-making incapacity."

Licensing Authority

When investigating within a facility, the counselor needs to see the license(s) under which the facility is operating. Facilities may have multiple licenses, depending on whom they serve. The facility may be unlicensed; if so, this should also be documented. The type of license held by the facility, or the lack of a license, determines how the investigation will proceed and influences the coordination of the investigative activities with other agencies. Confidentiality Policy - Chapter 2

Facility Investigations

Allegations of abuse, neglect and/or exploitation involving residents of institutions / facilities are to be reported to DHS the same as for adults who live in private residences.

Exception: The Department of Human Services shall not be required to investigate, and the Tennessee Department of Mental Health (TDMH) and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) shall not be required to report to TDHS, any allegations of abuse, neglect or exploitation involving its residents that occur within any facility operated directly by TDMH or DIDD. Allegations occurring in such institutions shall be investigated by investigators of TDMH or DIDD, as appropriate. This includes incidents that occur in a community residence licensed, owned and operated by either TDMH or DIDD **but does not include** allegations involving residents of such facilities if the incident allegedly occurred outside the premises of the facilities, or in facilities licensed by another authority. Such allegations shall be reported to and investigated by TDHS - APS.

Institutions Operated by TDMH

Memphis Mental Health Institute
Western Mental Health Institute
Middle Tennessee Mental Health Institute

Lakeshore Mental Health Institute
Moccasin Bend Mental Health Institute

Institutions Operated by DIDD

Clover Bottom Developmental Center
Greene Valley Developmental Center
Group Homes that are state owned and state staffed

In most cases in which APS conducts investigations in facilities or requires access to persons or information in facilities, APS will be dealing with the administrator of the facility. For this purpose, the administration assumes the role of the *caretaker*.

Entry into Health Care Facilities / Services and Private Facilities-
T.C.A. 71-6-103(e) and 71-6-103(k)(2)

Any representative of the Department may enter any health facility or health service licensed by the State of Tennessee at any reasonable time to carry out the responsibilities of the Department as they pertain to Adult Protective Services.

NOTE: See exception above regarding TDMH and DIDD.

In almost all instances, the residents of TDMH and DIDD facilities are assumed to be unable to protect themselves due to their disabilities. The administration, in the role of caretaker, is therefore expected to assume responsibility for protecting the residents. The administration of each institution / facility is responsible for providing supervision and protection for the residents. TDMH and DIDD regulations require that each institution develop written policy prohibiting mistreatment, neglect or abuse of residents, and establish a procedure for reporting and investigation of any such allegation.

During an APS investigation, the Social Counselor may uncover allegations of general complaints regarding the operation of or the care provided within a facility which do not pose an immediate risk to the client, *i.e.*, unsanitary conditions, dirty linen or cold food, etc. Such conditions may be violations of facility standards but may not be of such a nature or degree as to warrant a referral for an APS investigation. Referrals alleging violations of facility standards can be reported to the Complaint Coordinators at the following DIDD Regional Offices:

- East TN: 1-888-310-4613
- Middle TN: 1-800-654-4839
- West TN: 1-800-308-2586

APS / TDMH Investigations

Access to Records – TDHS APS

Any APS representative who is conducting an investigation shall be allowed access to the mental and physical health records of the client which are in the possession of the DMHDD staff or facility. In addition, APS will have access to any other relevant records necessary to complete the investigation, including, but not limited to, personnel, personnel history, staffing patterns, work schedules, etc. APS needs to ask for ALL records, including the incident report.

Exception: Drug and alcohol treatment records may not be released except by a court order or by a release signed by the patient. Therefore, these records **will not** be shared with APS **unless** a court order or release is provided to TDMH.

Confidentiality

APS may not make use of or disclose information obtained in the course of the investigation except as may be necessary to carry out the provisions of the Tennessee Adult Protection Act, or as may be authorized by the statute establishing the confidentiality of this information. T.C.A. 71-6-103(j)(5)

APS is prohibited from releasing **to anyone** the identity of the **person who reports** abuse, neglect or exploitation. Therefore, this information will **not** be shared with TDMH.

The Standing of TDMH, DIDD or Other State Agencies to Petition the Court Using the Adult Protection Act T.C.A. 71-6-103(k)(1)

The law provides that TDMH has the authority to petition the court under the Adult Protection Act when the following conditions exist:

- The referral of abuse, neglect or exploitation of an adult who is a resident of a facility owned and operated by TDMH has been investigated by APS, and the necessary protection of the adult has not been provided;
- A report of the APS investigation has been submitted, along with any recommendations for needed services to enable the adult to be protected, to the Commissioners of TDMH, DIDD or other state agencies; and
- A petition to the court is needed to enable TDMH, DIDD or other state agencies to meet their responsibility for providing the necessary protection of the adult.

Investigations in Licensed and Unlicensed Health Care Facilities (Department of Health)

The Tennessee Department of Health has the legal responsibility to license facilities which provide varying levels of health care services. These include:

- Homes for the aged which provide room, board and supervision or assistance with activities of daily living to ambulatory adults;
- Assisted-care living facilities (ACLF) which provide, in addition to the services specified above, assistance with typically self-administered medical needs;
- Nursing homes, with full-time, professional, licensed staff who have the ability to provide a higher level of residential care, including 24-hour assistance with essential daily activities and attention to medical needs;
- Hospitals which provide nursing, medical and/or surgical care for the diagnosis and/or treatment of deformity, injury and/or disease;
- Home health agencies; and
- Medical supply companies.

See list of facilities

The Department of Health, through its Health Care Facilities Division, has the duty to also ensure that these facilities comply with the State's minimum standards for safety and quality of services and that the needs of residents are appropriate for the level of care being provided. Due to the nature of their responsibilities for such facilities, Health Care Facilities surveyors will be in contact with adults who are vulnerable and may be in need of protective services.

The Tennessee Department of Health maintains health related boards which are responsible for licensing professional staff pursuant to Tennessee state law. The licensing board of each profession has the authority to discipline licensed members of the profession. Actions may include, but are not limited to, requiring additional training, suspending or revoking licenses.

The Tennessee Adult Protection Act (T.C.A. 71-6-101 et. seq.) mandates the Department of Human Services to provide protection to residents of licensed and unlicensed health care facilities just as it mandates protection for adults in other living arrangements. The law requires that Adult Protective Services staff receive and investigate reports of abuse, neglect, or exploitation of adults. The investigation and provision of services to adults in such facilities include:

- Notifying law enforcement and licensing authorities upon receipt of the referral;
- Making a timely response;
- Interviewing the adult client;
- Performing investigative tasks necessary for determining the risks to the adult;
- Assessing and providing appropriate intervention;
- Notifying appropriate agencies and boards of the investigative findings;
- Maintaining confidential records; and
- Notifying the referent after the investigation / assessment process has been completed.

The Department of Health, Division of Health Care Facilities' (HCF), scope of services includes the following:

- License health care facilities annually;
- Communicate licensing requirements to and facilitate the application process for unlicensed facilities;
- Conduct surveys for licensure and certification and ensure that state minimum standards are met and federal conditions of participation are complied with;
- Investigate complaints pertaining to licensed health care facilities;
- Investigate complaints pertaining to unlicensed health care facilities as the law permits; and
- Provide consultation to providers regarding the above.

Upon receipt of any complaint that alleges abuse, neglect and/or exploitation of an adult client or patient, the Division of Health Care facilities will immediately make a report to APS. In addition, any time that a Health Care Facilities employee observes, suspects or is made aware of the possibility of abuse, neglect or exploitation of an adult, a report will be made to APS intake. When abuse, neglect or exploitation is not identified in an initial complaint, but is confirmed during the course of an HCF investigation, the HCF staff will report this information to their Central Intake. The HCF Central Office staff will then add the new information into complaint details as an addendum and report to APS.

While conducting an APS investigation, APS staff may become aware of some general complaints regarding the operation of, or the care provided within, the

facility, such as dirty linen, cold food or unsanitary / unsafe conditions, which may be in violation of licensing standards, but are not of such a nature or degree as to warrant an APS investigation. In these cases, a call may be made to the TDOH Health Care Facilities Centralized Complaint Intake Unit at 1-877-287-0010.

Special Considerations for Investigations in Unlicensed Facilities

Search for licensed facilities and if not on the list, it may be unlicensed. Also see rules/law for licensure requirements.

The investigative process is essentially the same for APS in both licensed and unlicensed health care facilities except that HCF staff has no authority to enter the premises of an unlicensed facility, as it is essentially private property. Therefore, APS staff must recognize that HCF cannot enter an unlicensed facility, either with APS staff or independently, without the permission of the provider. Nor will HCF be conducting an investigation in the unlicensed facility. In all other matters of collaboration / sharing of information, the relationship between APS and HCF is the same.

TBI will need to advise APS staff of whether or not TBI has the authority to enter the unlicensed facility in question.

APS Investigations in Health Care Facilities

Joint investigations are strongly encouraged between APS and DOH HCF as circumstances permit. However, in many instances, DOH may not be able to respond as promptly as APS. APS will respond according to its policy time frames. Even when investigations cannot be conducted jointly, DOH and APS are encouraged to collaborate on investigative activities and assist one another as the law allows. If initiation occurs together, suggest communication prior to entering facility due to different guidelines. (DOH does not tell facility who the "client" is, they pull a sample of records containing the "client's".)

The following steps are recommended, as dictated by the needs of the specific case:

- The investigation will generally begin by contacting the facility administrator / operator. This is not a requirement and the decision is left to the discretion of the APS counselor. In some instances, such as when the alleged perpetrator is the administrator, it is best to begin by contacting the client or others who may have knowledge of the allegations. Regardless of the order in which the interviews are conducted, the cooperation of the administrator / operator will be requested during the investigation.
- Always see and interview the APS client (privately if all at possible), making all reasonable efforts to communicate with and observe the client.

Some clients who cannot communicate verbally may be able to convey reliable information with the use of appropriate tools such as figure drawings or dolls. Some clients may have more receptive than expressive language—that is, they may be able to respond to questions and statements with gestures, and or indicate feelings by facial expression and body language. All of these types of non-verbal responses, while not definitive, can serve to indicate to the APS counselor areas of information to pursue further with collateral contacts such as facility staff, family members, etc. In addition, the APS counselor will carefully observe and make special note of the client's physical condition, mental functioning, behaviors and status, including any injuries or indicators of neglect or maltreatment.

- Obtain medical examination / evaluation of the patient's physical condition, date and cause of injuries if existing records / reports do not provide the necessary information. If needed, DOH assistance may be requested to obtain examinations / evaluations.

- Review and obtain copies of any medical records, incident reports, staffing schedules, personnel records, etc., pertinent to the investigation.

- Medical records can be used to determine the adult's medical condition, treatment history and whether or not the physician's orders are being followed by facility staff. Medical records should document when illness or injuries were first noticed, what action was taken, etc.

- Request Department Of Health / Health Care Facilities assistance when needed to interpret records, charts, or to determine appropriateness of treatments or interventions which were used or suggested.

- Interview others who may have information which will assist in determining the client's condition, risk and need for services. These may include, but are not limited to, physicians, nurses, other staff of the facility, family members, other patients, etc.

- Check the State Abuse Registry to determine whether the alleged perpetrator has been previously indicated as a perpetrator.

- Interview the alleged perpetrator regarding his / her account and explanation of the allegations. Carefully compare this statement with other statements and evidence.

- Obtain from Department Of Health / Health Care Facilities a detailed investigative report showing its investigative contacts and conclusions.

- Complete the Safety and Outcome Assessment.

Action(s) To Protect the Client

In addition to the casework and legal options available to APS in all cases, there are additional considerations when attempting to protect residents of health care facilities. Necessary action will be based on the nature of the risk to the client and the steps which are necessary to eliminate the risk. APS will usually work with the client, interested family and/or the facility staff to correct the situation. In most cases, facility / nursing home administration and or DOH HCF should be able to take necessary steps to protect the client.

APS responsibilities are to:

- Review the actions taken by the facility and advise DOH / HCF when a licensed facility fails to take necessary action to protect the client.
- Utilize casework and legal remedies available to APS to protect clients in facilities.
- Coordinate with DOH to identify an appropriate facility and access to a bed when an adult needs to be moved to a different facility for his / her protection.
- Take appropriate legal action when needed to protect the client who is in imminent danger or at high risk, who is refusing needed placement and/or treatment, and has been determined to lack the capacity to make an informed decision. Court action is considered an intrusive intervention and is to be used only when no less drastic alternative is deemed effective or available. Other casework options must first be attempted:
    - Discuss the situation with the client / family.
    - Identify and allay any false fears and/or misinformation.
    - If the client still refuses, then determine the client's capacity to consent, seeking DOH assistance with obtaining evaluations, if needed. If the client refuses the evaluation, then contact the DHS attorney regarding a court order for **examination only**.
    - If the client is determined to have capacity to consent, then inform DOH that APS is unable to intervene.
    - If the client is determined to lack the capacity to consent, **and** the client is determined to be in imminent danger of irreparable harm or death, a referral to the DHS attorney should be made.
    - Each department (DOH & APS) will maintain its respective involvement until the risk to the adult has been eliminated and there

is no longer a need for services to protect the adult. These actions will be based on the state mandate for each department.

NOTE: APS will consult with the Department's attorney about obtaining an injunction that prohibits an **indicated perpetrator** from providing care to the victim or to other vulnerable adults, regardless of the actions of DOH, unless it is verified that the actions of DOH have included obtaining such an injunction.

Depending on the type of risks and concerns in an APS case, the Patient Care Advocate and/or Long-Term Care Ombudsman may be asked to assist in resolving identified problems.

Post Investigative Tasks

Investigative Reports

It is important for APS to share the results of the investigation with DOH HCF. The investigative report includes all information regarding the investigation and its outcome **except for the name of the referral source**, which remains confidential outside of APS. Before releasing the post-investigative report, APS staff should refer to the Confidentiality Policy. The APS report to DOH HCF is always limited to the investigative findings and concerns. It does **not** include any recommendations regarding actions to be taken. It is up to DOH to decide on and take appropriate action.

The agreements with DOH HCF state that APS reports will remain confidential, will be treated as a confidential part of the DOH files, and under no circumstances will APS reports / files become part of a public record. APS may share the investigative outcome with relevant law enforcement agencies and licensing boards if those entities request information.

Notifications for Healthcare Facilities

- APS will notify the referral source of the decision regarding the client's need for protective services at the conclusion of the investigation, always observing the need to comply with confidentiality requirements.
- The notification will be documented on Form 2638.
- APS will inform appropriate Health Related Boards of investigative conclusions that a licensed individual has been indicated as a perpetrator after completion of due process; however, the information will **not** include any recommendation for action. It is the board's responsibility to investigate and to determine whether or not any action will be taken regarding the individual's professional license.

Tennessee Vulnerable Person's Registry

The Tennessee Vulnerable Person's Registry is a list of persons who have been found to have committed abuse, neglect, or exploitation of a child or vulnerable adult. It is maintained by the Tennessee Department of Health, and the names and information contained on this Registry are available for public inspection. Some agencies and facilities that provide care or services to children, the elderly, physically / mentally disabled, or other individuals who are considered to be vulnerable are required to check the names of prospective employees against this registry before they are hired.

Pursuant to T.C.A. § 68-11-1004, APS can have a name added to the Registry by providing notice to DOH that a caretaker has been found by DHS to have committed abuse, neglect, or exploitation of a vulnerable adult, according to the APS procedures and definitions and following appropriate due process.

APS staff will have cause to access the Registry list for two different purposes:

- As part of the investigation requirements of an APS case, to determine whether an individual alleged as a perpetrator has been previously named as a perpetrator.
- At the conclusion of an APS investigation, when submitting to the DOH the name of a person who was indicated as a perpetrator and who has received appropriate due process – as specified in Chapter 2

Submitting an Indicated Perpetrator's Name to the Vulnerable Person's Registry

Placing the name of an indicated perpetrator on the Tennessee Vulnerable Person's Registry is a protective action that prevents the perpetrator from providing care to vulnerable adults.

DHS policy states that in order for an individual to be included on the Tennessee Vulnerable Person's Registry, the following conditions must be met:

- A thorough APS investigation was conducted and concluded. The case was found to be valid and there is sufficient information to indicate a specific person of abuse, neglect, or exploitation of a vulnerable adult; and
- The individual received due process as specified in Chapter 2.

To submit the name to the Registry, the information should be sent to the APS Program Supervisor for review and, thereafter, forwarded to:

Tennessee Department of Health
Vulnerable Person's Registry
227 French Landing, Suite 501
Heritage Place, Metro Center
Nashville, TN 37243

The following information should also be provided:

- A certified copy of the final court / administrative order (the court clerk's seal must be raised - not a photo copy) with a finding that the named perpetrator has committed the abuse, neglect, or exploitation.
- The indicated perpetrator's last known mailing address and Social Security number, which will permit the Department of Health to notify the person that his / her name is being placed on the Registry.
- The DHS APS definition of abuse, neglect and/or exploitation which was used in making the determination.
- The name of the facility in which the incident(s) occurred.
- The position / role of the person (*i.e.* nurse, technician, custodian, paid sitter, etc.).

See Sample Letter to Submit Name to Tennessee Abuse Registry

Accessing Information from the Abuse Registry
There are two ways by which APS can check the Abuse Registry to see if an individual's name has been placed on the registry.

Telephone
The number to access the Registry is 1-800-778-4504. This number is a toll free number with automated options. (In Nashville call 615-532-5171)

Internet

Connect to the Internet and go to the web site:
https://health.state.tn.us/AbuseRegistry/default.aspx

The Abuse Registry page will provide spaces to insert the name and/or the Social Security number of the person in question. Click on "Submit," and the results of the search will either provide information about the individual or will say that there is no record based on the information submitted.

Appendix C
CLASSIFICATION PRACTICE GUIDE

After the Social Counselor completes the investigation, he / she must organize, analyze, and weigh the investigation information to derive a classification for the investigation. The classification process is multi-tiered. The Social Counselor must determine, based on the assessment and evidence gathered, the disposition of the allegation, the perpetrator determination, the classification of the investigation and the need for continued APS intervention.

General Guidelines for Classification of a Case

It is critical to understand that classification of a case is a separate step of an investigation. Once an allegation has been addressed and a perpetrator has been determined, then a classification will be derived. If an allegation is unfounded, the case will be invalid. However, one might have an indicated allegation and an unfounded perpetrator which would result in the case being classified as valid.

The lack of disclosure by the client and the denial by the alleged perpetrator requires that corroborative information be sought through collateral contacts in order to resolve the conflict between the allegations of the referral and the denial by the alleged perpetrator.

General Considerations

- Hostility or cooperation on the part of the alleged perpetrator is not a deciding factor in classifying investigations.
- Although intent is a consideration in the investigation, intent is irrelevant to the classification of the investigation and determination of the perpetrator. For the purposes of Adult Protective Services intervention, abuse / neglect / exploitation of a vulnerable adult may occur even though the perpetrator did not intend to commit abuse / neglect / exploitation or believes that the client was safe and receiving adequate care.
- Intent **is** an important factor in problem solving and choosing interventions.
- Evidence must be gathered objectively and evaluated in such a way so as to either substantiate or dispose of the allegation of abuse, neglect or exploitation. Do not look only for information to support dismissing the allegations and do not look only for information which supports the allegations.

Indicated Allegation

- A credible statement from the alleged victim that the allegations occurred.
- An admission by the alleged perpetrator, if the allegations are other than self-neglect.
- Observation and verification of evidence of self neglect.
- The existence of an injury or a mark does not automatically lead to an indicated allegation. It must be determined if the injury or mark occurred as a result of abuse or neglect.
- To classify an allegation as indicated, there must be enough relevant indicators (facts) to prove that the alleged victim suffered the maltreatment.

Unfounded Allegation

- Denial by the alleged perpetrator or caretaker is not acceptable as the only rationale for classifying an allegation as unfounded. An attempt must be made to obtain collateral information. Denial is a strong factor in the profile of an abuser.
- The fact that the client denies the A/N/E is not reason, by itself, to classify an allegation as unfounded.
- A change by a client from admission to denial, alone, does not constitute an unfounded allegation. There are many reasons which cause a victim to protect his / her abuser.
- The inability of the client to talk, for any reason, is not justification for classifying an allegation as unfounded
- The lack of bruise marks or other physical injury is not by itself justification for not substantiating an abuse allegation.

Valid Classification

- At minimum there must be an indicated allegation.
- If several forms of maltreatment are alleged and the facts obtained do not support that all identified forms of maltreatment occurred, but there are enough facts to substantiate at least one form of maltreatment, whether or not it was alleged in the referral, the classification would be valid.

Invalid Classification

- No indicated allegations.

Conditions under Which Sexual Contact is Abusive:

With respect to sexual relations between adults, the only relevant question is whether both parties are able to give their informed consent. If there is no evidence of coercion or manipulation and both parties are able to give their informed consent and are free to leave the relationship at any time, the sexual relations fall outside the purview of APS.
Following are descriptions of conditions under which sexual contact would be considered to be abusive:

- Impaired adult is physically forced into sexual activity
- Impaired adult is pressured or manipulated into sexual activity
- Impaired adult is unable to grant informed consent
- Service provider has sex with impaired adult client (abuse of trust, authority and power)

Sexual Abuse Continuum

The Sexual Abuse Continuum, developed by Dr. Holly Ramsey-Klawsnik[1], delineates the range and types of sexually abusive behaviors. The activities listed are ranked in order from least to most severe in terms of the degree of violence and trauma to the victim. Sexual abuse often begins with the activities in the less severe range and escalates over time to more severe forms of abuse.

- **Covert Sexual Abuse**
  - Sexual interest in victim's body
  - Sexualized jokes or comments
  - Harassing "romantic" relationship
  - Discussion of sexual activity
  - Pre-touching phase

[1] Holly Ramsey-Klawsnik, Ph.D., A Publication for National Committee for the Prevention of Elder Abuse Affiliates, April 1998.

- **Overt Sexual Abuse**
  - Sexual voyeurism
  - Abuse exhibitionism
  - Inflicting pornography on victim
  - Sexualized kissing and fondling
  - Victim is passive recipient
  - Victim activity is forced
  - Oral-genital contact
  - Digital penetration of vagina or anus
  - Vaginal rape with penis
  - Anal rape with penis
  - Vagina / anal rape with objects
  - Exploitation
  - Sadistic activity
  - Ritualistic abuse

Signs and Symptoms of Possible Elder Sexual Abuse

The following is a list of signs and symptoms of possible elder sexual abuse developed by Dr. Holly Ramsey-Klawsnik. These signs / symptoms should also alert the counselor to possible sexual abuse of adults of any age who are disabled. The presence of one or more of the following indicators does not mean that sexual abuse is occurring, but should suggest the possibility, prompting the counselor to carefully screen for sexual victimization.

- Genital or urinary irritation, injury, infection, or scarring
- Presence of a sexually transmitted disease
- Intense fear reaction to an individual or people in general
- Nightmares, night terrors, sleep disturbances
- Phobic behavior
- Mistrust of others
- Extreme upset when changed, bathed or examined
- Regressive behaviors
- Aggressive behaviors

- Disturbed peer interactions
- Depression or blunted affect
- Poor self-esteem
- Self destructive activity or suicidal ideation
- A coded disclosure of sexual abuse

Appendix D
SAFETY ASSESSMENT / OUTCOME MEASUREMENT PRACTICE GUIDE

Assessment of the Adult's Condition and Circumstances

The Pre-Safety Assessment / Outcome Measurement tool will be completed based on the information obtained during the investigation that describes the client's circumstances **prior** to APS intervention. The completion of the Pre-Safety Assessment may occur at any point at which the information is known to the counselor, but must occur within 60 days of the date of assignment. The entire assessment instrument does not need to be completed at one time, but may be completed in stages, as the information is gathered. When completed, the counselor is able to review the auto-calculated safety level score and determine if an accurate picture of the client's circumstances has been created. If the counselor disagrees with the auto-calculated safety level score, the counselor may override the score. An explanation of the need to override must be provided.

After investigation, the APS staff will complete the Closure Assessment if the case is to be closed or the Post Investigation / On Going Services Assessment if the case will remain open. If services are provided during the investigation, whether formal or informal, the instrument will assist the APS staff in identifying which services effectively reduced risks, improved the safety levels of the client, and will assist in determining the need for closure or for providing ongoing services.

The Periodic-Safety Assessment / Outcome Measurement will be used every 6 months in an active case to determine if the services being provided are achieving the desired outcomes and to identify any changes in the ratings of the elements. In a case in which APS has custody of a client, the Periodic-Safety Assessment will be used every 6 months to determine whether or not the client needs to remain in APS custody. A Periodic-Safety Assessment is also recommended at any time there is a significant change in a client's circumstances. At the completion of an on-going services case, a closure assessment will be completed.

All areas which impact the client's circumstances and need for protection are pertinent to the decision-making process and are critical in determining the action to be taken by the Department.

In general the assessment will consider the following:

Environment - Type of shelter, condition of shelter, utilities, housekeeping, safety hazards, and potential for eviction.

Financial – Income / monetary source(s) and amount, insurance, Medicare / Medicaid eligibility, pensions and source of the pension, property, expenses,

debts, and potential for exploitation – for exploitation under the Adult Protection Act, funds must be paid by a governmental source.

Physical Health - Problems as identified by the client, medical professionals or observed by the counselor or others (malnourishment, dehydration, lumps, cough, headaches, sores, pain, bleeding, dizziness, shortness of breath, weight loss, weight gain, vision, hearing, etc.), medications, last visit to the doctor, etc.

Mental Health - Problems as identified by client, medical professionals or observed by the counselor or others (loss of appetite, insomnia, feelings of worthlessness, depression, suicidal ideation, memory loss, hypochondria, suspiciousness, hallucinations, confusion, etc.)

Substance Abuse - Use of alcohol or drugs (prescription medications or illegal substances)

Developmental Disabilities - Problems identified by the client, medical professionals or observed by the counselor or others (mental retardation, cerebral palsy etc.)

ADLs - physical / mental abilities – performing activities of daily living (ADLs) - prepares food / eats without assistance, gets dressed without assistance, uses toilet without assistance, gets out of bed, does light house-work, climbs stairs, walks outdoors, shops, does heavy housework - mobility (bedridden, wheelchair user, house-bound, yard bound, neighborhood bound, uses public transportation, drives car)

Informal Supports - Known and visited by neighbors and/or relatives, participates in community or other group activities, availability of family or friends who are willing and able to assist the client and take action when needed

Formal Support - Identify agencies currently assisting client and the availability of other needed services. Include agencies previously involved and reason services were discontinued.

Caretaker - This will include the caretaker, his / her skill level and willingness to provide care, as well as any physical / mental health issues the caretaker is known to have, whether there is a need for a caretaker but no one is available, and whether the caretaker has legal authority over the adult through a conservatorship or a durable power of attorney for health care.

Elements of Abuse / Neglect - Contact with the alleged perpetrator, available protection for the client by others, etc., unexplained injuries, bruises, burns, etc., injuries not consistent with innocent explanation, critical services being withheld, necessary supervision not being provided, minimal daily needs not being met.

NOTE: The elements of self neglect are located in the various domains of the safety assessment. This includes all the domains except for Caretaker and Elements of Abuse and Neglect. It is incumbent upon APS staff to be mindful of self neglect. While not specifically addressed as a domain, it is most likely to be an issue that frequently occurs and makes up more than half of the referrals to APS.

Client's Perception of Problems - This will include a statement or discussion of what the client sees as the problem(s).

What the Client Wants - When there are several problems, this may entail the client prioritizing the problems.

Risk to the Client - What dangers exist for the client? Is abuse, neglect or exploitation occurring? What intermediate to high risk factors are present? What do they mean? In what area is the client found to be vulnerable? In what area is the client found to be in crisis?

Each area to be evaluated contains levels of safety ranging from crises to thriving or not applicable. In conjunction with the various levels of safety, there are several factors listed within each category to be used as a guide in determining which level of safety most accurately describes the client. In addition, the Risk Factor Matrix, see below, is a work-aid to be used in conjunction with determining the levels of safety. While the risk factor examples are not exhaustive, they can be used as suggestions to assist counselors in assessing and documenting the client's level of safety. Careful consideration must be given to the person as a whole when critical decisions are made.

Written Report – The law requires a written report of the initial findings and a recommendation for further action. The completed Pre-Safety Assessment, Post Investigation / Ongoing Services Safety Assessment, Closure Assessment and service action plan will meet the requirements under the law in most cases. However, cases which require legal action will also have the Request for Legal Intervention in the electronic record. In the event that a client cannot be located and a Pre-Safety Assessment cannot be completed, the electronic record should contain the referral information, any client demographic information that is known, and the justification and supervisory approval for "closure without investigation."

Safety Assessment/Outcome Measurements Matrix

ENVIRONMENT

Crisis	Vulnerable	Stable	Thriving
Structure is unsound, has been condemned, or is dangerously unsafe.	Shelter is deteriorating, some broken windows, or holes in walls or floors.	Structure has minor structural problems, broken window, some repairs required.	Shelter is sound, no repairs needed.
Utilities are disconnected or inoperable creating immediate risk.	Utilities are disconnected or inoperable but risk is intermediate.	Utilities are in working order most of the time.	Utilities are operable and no history of disconnections.
Client is homeless or being evicted and weather conditions are very dangerous.	Client is homeless or threatened with eviction but weather only poses intermediate risk.	Client is homeless or eviction is pending, but weather makes risk minimal.	Client is not homeless or being threatened with eviction.
Residence in high crime area, client has been victimized repeatedly.	Residence is in an area that puts client at risk for being the victim of a crime.	Residence is in an area with a low risk of criminal activity.	Residence is in an area with little or no criminal activity.
Most areas of the household are not accessible due to dangerous accumulations of trash or personal belongings.	Some areas of the household not accessible due to accumulations of trash or personal belongings, intermediate risk.	A few areas of the household are not accessible due to clutter or personal belongings, low risk.	All household areas are accessible and there is little to no clutter.
Residence is in a high traffic area and client's wandering puts them at high risk.	Residence is in an area moderate amount of traffic and client tends to wander.	Residence is in a location that poses low risk to a wandering client.	Residence location and client behavior poses little or no risk.
Severe pest infestation with bugs, mice or rats evident in the food, bed linens, dishes, or on the client with no effort made to control the pests.	Intermediate evidence of pest infestation with some indication of an effort to control the pests.	Some evidence of a reoccurring pest infestation but efforts to control the pests keep the problem to a minimum.	Little or no evidence of any pest infestation.
Extreme filth in the residence, including the visible presence of human or animal urine or feces.	Some areas of the house are dirty and there is some evidence of human or animal waste.	Some odor of human or animal waste exists but there is no visible evidence.	There is no evidence or odor of human or animal waste.

FINANCIAL

Crisis	Vulnerable	Stable	Thriving
Client has no income, is totally dependent on others for finances, basic needs are unmet putting client at high risk.	Client's income is not sufficient to meet most basic needs, choosing between necessities putting client at intermediate risk.	Client has limited income but most basic needs are met with low risk to safety.	Client has sufficient income and all basic needs are met.
Client is unaware of financial resources, depends on others to manage money, or refuses needed assistance with money management.	Client needs assistance with finances, gives money away despite own needs, is not sure how and where money is spent.	Client occasionally needs help with managing money but for the most part keeps bills paid without help.	Client is able to manage their own money and knows where and to whom it goes, bills are paid consistently.
Client's money is being taken or misused resulting in the loss of food, shelter, medicines and other basic necessities.	Client's money shows a pattern of misuse which without intervention will result in a lack of basic necessities.	Client's money is being taken or misused but minimal basic needs are usually met.	There is no indication that the client's money is being taken or misused.
Client is unaware of finances and alleged perpetrator has full access to the client's money.	Client is unaware of finances but alleged perpetrator has only sporadic access to the funds.	Client is unaware of finances; but, responsible parties restrict alleged perpetrator's access.	Client is unaware of finances; responsible party managing money and no indication of exploitation.
Client has sufficient income but standard of living does not match resources.	Client has sufficient income but bills are paid sporadically resulting in loss of utilities, food or medication.	Client has sufficient income but needs occasional assistance with finances.	Client has sufficient income and manages income independently.

PHYSICAL HEALTH

Crisis	Vulnerable	Stable	Thriving
Bedfast	Difficulty ambulating; requires prosthesis (cane or walker) or hands on help to ambulate.	Occasionally non-ambulatory; ambulatory with a wheelchair or assistive device.	Ambulatory without assistance.
Chronic or acute potentially life threatening illness or condition.	Chronic illness, non life threatening but requiring continuous care or treatment.	Occasional flare up of chronic illness; medical conditions are controlled by regular medical checkups.	No chronic medical problems, generally healthy.

Client has decubitus ulcers and bedsores.	Client has evidence of skin break down and is not receiving treatment.	Client has evidence of skin breakdown but is receiving treatment.	No evidence of skin breakdown or discoloration of the skin.
Client has been diagnosed or appears to be malnourished.	Client appears to be malnourished.	Client's minimal nutritional needs are being met.	Client is not in any need of treatment or services.
Client is dehydrated; client has continuous thirst AND water is not available.	Client states they are continuously thirsty and have difficulty getting water.	Client says she stays thirsty but can get water to drink when she needs it.	Client has no indicators of dehydration.
Medical emergency. Has critical unattended health needs. Refuses critical medical services, unable to obtain needed medication, insufficient diet has resulted in serious health problem.	Some observable health needs and not receiving medical care or medicines; has chronic condition or advancing age and receiving no medical care or follow up; insufficient diet. Non compliant with medical advice and treatment.	No obvious unmet health needs, has not seen doctor recently, some assistance needed with care and medication.	Medical and health needs are being met. Medical conditions are being controlled.

MENTAL HEALTH

Crisis	Vulnerable	Stable	Thriving
Constant confusion	Periodic confusion	Minimal confusion	No confusion
Severe uncontrolled mental illness including untreated depression.	Decompensate form of mental illness, some evidence of depression.	Minimally controlled mental illness, depression that is being treated.	No evidence of any untreated mental illness.
Obvious lack of capacity to consent, lacking the ability to make informed decisions.	Capacity to consent is questionable or fluctuates, obvious short term memory loss.	Minimal short term and or long term memory loss.	Client appears to be able to make informed decisions.
Client refuses needed mental health treatment or services.	Client resists needed treatment or services.	Client needs services and is open to receiving services.	Client is not in need of any mental health services or is on medication and mental health condition is stable.

SUBSTANCE ABUSE

Crisis	Vulnerable	Stable	Thriving
Chronic alcohol or substance abuse.	Episodic alcohol or substance abuse.	Infrequent episodes of alcohol or substance abuse.	No evidence or history of alcohol or substance abuse.
Obvious lack of capacity to consent due to substance abuse, inability tom make informed decisions.	Capacity to consent is questionable and there is an obvious loss of short or long term memory.	Minimal evidence of short or long term memory loss due to alcohol or substance abuse.	Client appears to be capable of making informed decisions regardless of substance abuse.
Client refuses needed treatment or services.	Client resists needed treatment or services.	Client needs services and is open to receiving them.	Client does not need any services.

DISABILITIES

Crisis	Vulnerable	Stable	Thriving
Severe and functionally physical and mental limiting disability.	Moderately severe physical or mental disability.	Minimal severe physical or mental disability.	No severe physical or mental disability.
Has a diagnosis of mental retardation, cerebral palsy, autism epilepsy, or traumatic brain injury AND requires extensive assistance which is rarely or never available or client refuses assistance.	Has a developmental disability and needs substantial assistance, which is often not available or is refused by the client.	Has developmental disability and needs occasional assistance and resources are available most of the time and client accepts help.	Has developmental disability and has assistance which the client will accept when and if needed.

ACTIVITIES OF DAILY LIVING

Crisis	Vulnerable	Stable	Thriving
Completely dependent on others for bathing and dressing.	Requires intermediate amount of assistance with bathing and dressing.	Requires only a little assistance with bathing and dressing.	Client is able to bathe and dress without assistance.
Completely dependent on others for toileting, incontinent, wears adult diapers that must be changed.	Requires substantial assistance with toileting, needs help with diapers, transferring to potty chair or use of bed pan.	Requires minimal assistance with toileting.	Client is able to attend to all toileting needs without assistance.

Client is unable to feed self.	Requires moderate degree of assistance with eating meals.	Requires a little assistance with eating meals, food cut up, cartons opened.	Client is able to feed self independently.
Client is unable to prepare any meals of any type.	Client is unable to prepare anything other than simple meals that require almost no cooking.	Client is able to heat prepared meals in micro-wave, open cans, operate cook stove.	Client is able to prepare all types of meals independently.
Client is unable to do any grocery shopping or pay bills without assistance.	Client requires a lot of help with grocery shopping and paying of bills.	Client can do grocery shopping and pay bills with only a little Assistance.	Client does not require any help with grocery shopping or the paying of bills.
Client is unable to do any household chores.	Client needs substantial assistance with all household chores.	Client needs only a limited amount of help with household chores.	Client is able to do all household chores independently.
Client cannot take and manage prescribed medications without assistance.	Client can take and manage medications with some direction.	Client can take and manage medications with minimal direction.	Client is able to take and manage medications independently.
Totally dependent on others for ADL's AND no one is available OR person available is incapable of meeting client's needs OR refuses to provide care; client refuses all assistance AND is totally dependent on others for ADL's.	Needs substantial assistance with any ADL's and dependable assistance is rarely available OR available persons are incapable OR unwilling to meet client's needs OR client refuses help.	Assistance needed with ADL's and assistance is inconsistent or sporadic.	Able to meet needs independently or assistance is available as needed.

INFORMAL SUPPORTS

Crisis	Vulnerable	Stable	Thriving
Client has no transportation options.	Client can arrange transportation but dependability and availability are questionable.	Client is usually able to arrange for transportation for necessary appointments.	Client has transportation available and accessible whenever it is needed.
Client has no relatives or friends able or willing to assist or geographically available.	Relatives or friends available to assist but have limited skills or knowledge of resources and are not always available.	Relatives or friends available and willing to assist but need some direction and assistance from outside agencies.	Relatives or friends available and willing to assist and are knowledgeable, dependable and capable

Critical services are not available in client's area posing significant risk to the client.	Many necessary services are not available in the client's area, but danger to client is moderate.	A few services are not available to the client, but pose only minimal danger to the client.	All or most critical services are available to the client.
Client is isolated from community services physically, socially, or geographically posing significant risk to the client.	Client is somewhat isolated from community services by lack of knowledge, or cultural barriers, placing client at moderate risk.	Client is minimally isolated from community services by lack of knowledge or cultural barriers but seems willing to be educated	Client is not isolated from community services by any physical, social, or geographic barriers.

FORMAL AGENCY SUPPORTS

Crisis	Vulnerable	Stable	Thriving
Client has no transportation options.	Client is able to arrange for transportation but dependability and availability are questionable.	Client is usually able to arrange for transportation through some means for necessary appointments.	Client has transportation available and accessible whenever transportation is needed.
Critical services are not available in client's area posing significant risk to the client.	Many necessary services are not available in the client's area, but safety risk is intermediate.	A few services are not available to the client but pose only a low safety risk to the client.	All or most services are available to the client.
Client is isolated from community services physically, socially and geographically posing significant risk tom the client.	Client is somewhat isolated from community services by lack of knowledge, cultural barriers, placing the client at intermediate risk.	Client is minimally isolated from community services by lack of knowledge or cultural barriers but seems willing to learn.	Client is not isolated from community services by any physical, social or geographic barriers.

CARETAKER/PERPETRATOR

- These risk factors combine both Caretaker and Perpetrator
- Usually one and the same person
- But Not Always!
- The Safety Assessment is addressing Risks, look at how one may cancel out the other, keep focus on the safety of the CLIENT

CARETAKER/PERPETRATOR LEVEL OF COOPERATION WITH INVESTIGATIVE PROCESS

Crisis	Vulnerable	Stable	Thriving
Refuses to cooperate with investigation, refuses to allow access or privacy for the interview.	Is resistant to allowing access to the client or privacy for the interview and resists the investigation.	Is uncomfortable with allowing access to the client or privacy for the interview but does.	Is fully cooperative with the investigation and allows full access to the client.
Actively sabotages services for the client.	Attempts to manipulate service providers or makes a commitment and does not follow through.	Follows established action plan with only minor deviation or reluctance.	Cooperated fully with service provision and case planning.
Does not believe a problem exists despite evidence to the contrary and refuses to take action to protect the client.	Is skeptical that a problem exists and is reluctant to take suggested action necessary to protect the client.	Is doubtful that a problem exists but agrees to take necessary action to protect the client.	Believes that a problem exists and is willing to take whatever steps are necessary to protect the client.

CARETAKER/PERPETRATOR ACCESS TO THE CLIENT

Crisis	Vulnerable	Stable	Thriving
Has unrestricted access to the client.	Access to the client is interrupted by the presence of others in and out of the home.	Access is limited by others in the home that are protective; rarely alone with the client.	There is no unsupervised access to the client.
Has 24 hour care-giving responsibilities.	Sporadic assistance is provided by others.	Multiple shifts of caretakers.	Never alone or unsupervised with the client.
Client is isolated and dependent on caretaker and/or perpetrator for total care.	Others are involved in the care of the client for brief periods.	Limited opportunity to be alone with the client.	Never unsupervised with the client.

CARETAKER/PERPETRATOR FINANCIAL DEPENDENCE ON CLIENT

Crisis	Vulnerable	Stable	Thriving
Is totally financially dependent on the client and provides little OR no care for the client.	Receives partial financial support from the client.	Receives occasional financial support from the client.	Is totally financially independent.

Has a history of exploitive behavior.	Displays indications of opportunistic behaviors.	Is caring for client because of the financial needs of the caretaker.	Is financially independent of the client.

CARETAKER/ PERPETRATOR QUALITY OF CARE

Crisis	Vulnerable	Stable	Thriving
Demonstrates poor understanding of the client's needs and is blaming or hypercritical.	Has unrealistic expectations of client, inexperienced in care giving at the level client requires or displays resentment toward the client for needing care.	Unrealistic expectations; err on the side of being overly protective or overly solicitous of the client.	Is knowledgeable about client's needs and abilities and provides necessary level of care.
Responds to client's behavior with physical measures that are inappropriate (slapping, spanking, hitting).	Responds to client's behaviors with verbally abusive language and gestures.	Responds to client's behaviors with occasional verbal threats that are inappropriate but not physically damaging.	Responds to client's behavior in an appropriate non-threatening and compassionate manner.
Is using the client's resources to benefit someone other than the client, selling medications for personal gain.	Is using the client's resources to buy alcohol or drugs or is taking the client's medications.	Is occasionally using client's resources to purchase alcohol or drugs but client's basic needs are met.	Resources and medications are being used only to provide for the client's care.

CARETAKER/PERPETRATOR HISTORY OF SUBSTANCE ABUSE

Crisis	Vulnerable	Stable	Thriving
Has a severe alcohol/ substance abuse problem that causes significant risk to the client.	Has chronic alcohol/substance abuse problem that sometimes interferes with ability to provide care.	Has a controlled alcohol/ substance abuse problem that has little or no observed negative impact on the client.	Has no known alcohol or substance abuse problems.

CARETAKER/PERPETRATOR MENTAL AND EMOTIONAL HEALTH

Crisis	Vulnerable	Stable	Thriving
Has a severe mental or emotional impairment.	Has a mild mental or emotional impairment.	Has a mental or emotional impairment that is controlled with medication.	Has no mental or emotional impairment.

CARETAKER/PERPETRATOR PHYSICAL HEALTH

Crisis	Vulnerable	Stable	Thriving
Has an illness, condition or a recent physical decline that severely impairs ability to provide care.	Illness or condition requires services to be provided to the caretaker to enable them to provide care to the client.	Has some minor illness or physical problem that impacts only minimally on the caretaker's ability to provide care.	Is in good physical health and is able to provide good care to the client.

CARETAKER/PERPETRATOR/VICTIM DYNAMICS

Crisis	Vulnerable	Stable	Thriving
Client feels a need to protect the caretaker/perpetrator or has a relationship that allows the client to tolerate A/N/E.	Client denies or minimizes the situation involving the caretaker/ perpetrator.	Client regularly makes excuses for the caretaker/ perpetrator's shortcomings or failure to provide care.	Client recognizes that caretaker/ perpetrator's actions are inappropriate and is willing to take action.
Client does not have the cognitive skills needed to identify or recognize the situation as a problem.	Client's periodic confusion prevents a full understanding of the danger in the caretaker/ perpetrator's actions.	Client is sometimes confused and needs to be reminded that caretaker/ perpetrator is not acting in their best interest.	Client is fully cognizant of caretaker/ perpetrator's action and is willing to accept intervention to protect self.

ELEMENTS OF ABUSE/NEGLECT/EXPLOITATION AND SELF NEGLECT

PHYSICAL ABUSE

Crisis	Vulnerable	Stable	Thriving
Client has serious injuries that require immediate medical treatment or hospitalization.	Client has experienced an increase from minor injuries to ones increasing in severity.	Client has history of accidental minor injuries.	Client has no injuries and no history of accidents or minor injuries.
Injuries to head, face or genitals, old and new bruises welts, burns or broken bones.	Visible injuries or broken bones that are not consistent with the story being told.	Visible injuries or broken bones but the story is plausible.	No visible injuries other than minor bruises to places where it is expected.

Alleged perpetrator has full access to the client and there is no one to protect in the home.	Alleged perpetrator in the home but access is limited by other protective adult in the home.	Alleged perpetrator has only limited supervised access to the client.	Alleged perpetrator has no further access to the client.

EMOTIONAL ABUSE

Crisis	Vulnerable	Stable	Thriving
Client traumatized due to prolonged social or emotional isolation.	Client shows adverse effects of psychological abuse, depression, fear, anxiety.	Incidents limited to verbal abuse with no apparent long term effect on client.	No evidence of emotional abuse.
Client, client's property, pets, children or grandchildren being threatened with destruction or injury.	Client is subjected to yelling, cursing, screaming, insults, humiliation or ridicule that has a negative impact.	Client's needs, moans or cries are ignored or not responded to promptly.	Client's needs or requests for help are promptly responded to with compassion and respect.
Client is self abusive or displays fear of caretaker or others.	Client acts out or is combative with caretakers or others, is self blaming.	Client appears reluctant to talk or answer questions in the presence of caretaker or others.	No evidence that client is afraid or feels threatened by caretakers or others.

SELF NEGLECT

Crisis	Vulnerable	Stable	Thriving
Immediate hospitalization or medical treatment needed due to client's failure to seek or obtain treatment.	Prolonged time exists between illness and client's seeking medical care.	Client must be encouraged to meet minimal medical care needs.	Independently seeks needed medical treatment or hospital care when needed.
Client fails to seek or follow any medical treatment.	Client seeks medical treatment but is non compliant with doctor's orders.	Client attempts to follow medical regimen but fails to do so.	Client seeks medical treatment and adheres to prescribed regimen.
Client unable to do ADL's independently due to physical or mental limitations.	Client needs in home services and assistance with ADL's to maintain independence.	Client is able to do some ADL's independently and meets basic minimum needs.	Client performs all ADL's independently and meets needs adequately.
Regardless of income, client unwilling or unable to spend for necessities, refuses or resists assistance.	Client reluctant to admit to unmet needs and is resistant to accepting services.	Client reluctant to admit to unmet needs but is willing to accept some assistance.	Client recognizes own need for assistance and accepts services.

Client needs glasses/ hearing aids and / or walking aids to provide for their own safety but does not have them and cannot obtain them.	Client fails to use needed glasses, hearing aids and/or walking aids.	Client occasionally uses glasses or hearing aids and /or walking aids.	Client always uses needed glasses, hearing aids or walking aids.
Client has body odor, unwashed hair, untrimmed finger or toe nails, needs dental care, visible dirt or stains on body or clothing and presents a health hazard.	Client is frequently disheveled looking, has visible dirt or clothing not appropriate for the season and it is not a life choice and it is not a health hazard.	Client fails to bathe and/or change clothes regularly, hair sometimes not combed or washed, nails need cleaning and it is not a life choice and it is not a health hazard.	Client appears clean and well groomed with clothing appropriate for the season or it is a life choice and is not a health hazard.
Client has isolated self from family and community either emotionally or geographically causing risk to be high.	Client in conflict with family and neighbors; will not allow them to assist with care, placing client at intermediate risk.	Client's family and neighbors are geographically close but not always reliable, placing client at low risk.	Client has family and friends who are reliable and supportive and the client is willing to accept their assistance as needed.

SEX ABUSE

Crisis	Vulnerable	Stable	Thriving
Client is non verbal and unable to communicate.	Client has difficulty with communication and needs assistive device or interpreter.	Client has some communication barriers but can make their self understood.	No communication barriers exist.
Client has ongoing genital or urinary tract irritation, infections or scarring and UTIs are not explained by medical conditions. .	Client has genital or urinary tract irritation and infections frequently.	Client has genital or urinary tract irritation or infections occasionally.	Client has normal genital or urinary tract problems.
Client has obvious injuries to genitals, upper torso or inner thighs.	Client has indication of bruises to genitals, upper torso or upper thighs.	Client has a bruise to genitals, upper torso, or upper thighs.	No injuries to genitals, upper torso or upper thighs.
Client has a sexually transmitted disease due to abusive sexual contact.			Client does not have a sexually transmitted disease.

Client requires significant “hands on” assistance with personal care (bathing, dressing and toileting) and there are signs of sexual abuse.	Client requires daily assistance with personal care including bathing, dressing and toileting.	Client needs some assistance with personal care including bathing, dressing and toileting.	Client does need assistance with bathing, dressing or toileting.
Client is being fondled, touched, or kissed in a sexual manner by caretaker.	Client indicated discomfort with caretaker while being bathed, dressed or toileting.	Client receives assistance as needed with bathing, dressing and toileting.	No indicators of sexual abuse.
Client is forced to view pornographic materials or sexual acts.	Client has seen and is uncomfortable with pornography and/ or acts of a sexual nature.	Client may have seen pornography and sexual acts but it was not intentional.	Client has not been exposed to pornography or sexual acts.
Client must endure forced nudity and is not allowed privacy for bathing or dressing.	Client has little or no privacy for bathing or dressing which bothers the client.	Client’s privacy is intruded upon with little or no thought by the caretaker but no obvious affect.	Client’s privacy for bathing, dressing and toileting is respected.
Client lacks the capacity to consent to sexual acts or activities.	Client’s capacity to consent to sex is questionable.	Client probably has the ability to consent but may be unduly influenced.	Client has the ability to consent to sex and there are no indicators of sexual abuse.

NEGLECT

Crisis	Vulnerable	Stable	Thriving
Client is at risk of death or serious harm due to lack of care or supervision by the caretaker.	Deprivation of supervision or basic daily needs resulting in intermediate risk to the client.	Supervision or provision of care for basic needs is sporadic placing the client at low risk.	Client’s need for supervision and provision of care for basic needs are being met by the caretaker.
Client’s needs for hearing aid, glasses, dentures, walking aid are being ignored by the caretaker.	Client’s needed hearing aid, glasses, dentures, walking aid are available but are being withheld by the caretaker.	Caretaker is attempting to meet client’s needs for hearing aid, glasses, dentures and walking aid.	Client’s needs for hearing aids, glasses, dentures and walking aid are being met by the caretaker.
Prolonged time between serious illness or injury and the obtaining of medical care by the caretaker.	Medical care obtained reluctantly and treatment plan is followed haphazardly by the caretaker resulting in intermediate risk to the client.	Medical care is obtained and the treatment plan is followed by the caretaker with only a minimal need for encouragement and direction.	Client’s need for medical care is met in a timely manner by the caretaker and medication or treatment plan is followed.

Interference by the caretaker prevents the client from being interviewed alone and or from receiving necessary medical services.	Caretaker is resistant to allowing the client to be interviewed alone or to receive services placing client at intermediate risks.	Caretaker attempts to prevent private interview or provision of services but cooperates after some persuasion.	Client is allowed privacy for interview by the caretaker and is able to receive services that are necessary to protect the client.
Client is being punished, improperly restrained, confined or isolated from others.	Client is being threatened with punishment or is the subject of hostile or mean spirited jokes.	Client is being manipulated on how to feel or how to think.	Client does not appear to be experiencing any verbal or mental threats or hostility.

Appendix E
ON-GOING SERVICES PRACTICE GUIDE

Action Plan

At the time of assessment, the Action Plan will be completed with each client for whom on-going protective services are appropriate. The purpose of the action plan is to give direction to efforts to alleviate or reduce identified problems / risks by specifying actions to be taken and resources to be utilized.

The Action Plan needs to be reasonable and appropriate based on the needs of the individual client. The Action Plan documents the need for protective services after the investigation. It must also clearly document the need for each specific service recommended for the client. When the investigation and assessment are completed, the counselor will have determined whether:

- The reported allegations are valid;
- There are any problems or risks requiring protective services which were not identified in the referral;
- There were any service needs identified during the investigative / assessment phase;
- Appropriate interventions were provided to reduce initial identified risks;
- The client is in need of on-going protective services;
- The client will accept help; and
- Legal intervention is needed.

The Action Plan is based on:

- The client's perception of the problem;
- The counselor's perception of the problem;
- The client's motivation and capacity to address the problem; and
- The resources available.

The client must be involved in the development of the action plan to the extent possible. The counselor and the client may see the problem from different perspectives. The APS perception of the problem should be objective and professional, while the client will be more inclined to "feel" the problem and may be too close emotionally to be objective. The relationship and rapport developed with the client will play an important role in resolving the problem.

When a client is resistant to working on a critical problem, it may be helpful to work on lower priority problems first. Success in resolving the less critical issues may allow the client to feel more comfortable, in control and trusting, allowing APS intervention to address more serious issues.

The action plan should be revised, through Periodic Safety Assessments and Outcome Measurements, to reflect changes as they occur. The plan is a step-by-step process of problem solving to reduce risks and to provide an adequate level of safety for the client. Sometimes a client's situation will require that services be provided during the investigative / assessment phase. If action is taken to resolve an immediate crisis, or to reduce risks identified during the investigative / assessment phase, that intervention should be documented during the investigation / assessment phase on the Safety Assessment and Outcome Measurement form.

Periodic Safety Assessment / Outcome Measurement

When receiving services directed toward preventing abuse, neglect and exploitation, the client's need for services must be substantiated by the information contained in the case recording and Periodic Safety Assessment / Outcome Measurement.

A Periodic Safety Assessment / Outcome Measurement is due 6 months after completion of the case assessment and at least once every 6 months thereafter. Each assessment will explain the continued need for protective services, indicating the changes which have occurred and which services are needed. Additional assessments should be completed whenever there are major changes in the client's situation or service needs.

Summarize in narrative form any significant changes in the client's circumstances and/or situation since the preceding assessment. Special emphasis should be placed on the degree of successful reduction in previously identified risks and by which service alternatives / interventions they were achieved. After summarizing changes, risk reductions, and services rendered, identify new or continued areas of risk which substantiate an ongoing need for Adult Protective Services, including the current Overall Level of Safety. Justification is required if the calculated overall risk for the assigned safety level is overridden. As in the initial assessment, any revised Action Plan and the strategy for implementation should be addressed. If previously identified risks have been fully alleviated, and no new risks have been identified, then the APS case should be closed.

Frequency of Planned Contacts

Regular contacts must be maintained with the client. A minimum of one (1) visit per month is expected. If the Social Counselor questions the need for the one (1) visit per month, then the need for on-going protective services would also be

considered questionable. Contacts should be planned and focused according to the needs of the client. While there is a minimum of one (1) visit per month, most clients may require more than one (1) contact per month due to the seriousness of the issues.

Each contact should be made with a definite purpose in mind. The case recording reflects the on-going effort to evaluate and/or reduce risks to the client and/or evaluate the client's continued need for services or changes in service needs.

Planning Services for the Client

There will be situations in which the client's need for protection is clear, such as the critically ill client who is unable to make decisions and has no one available to make those decisions. However, the majority of cases will require a difficult decision as there is often no clear-cut point at which the client is no longer capable of managing without help.

In serving clients it is important for APS to give as much attention to a client's capacity for adequate functioning as to the incapacities. Remaining abilities need to be preserved and possibly enhanced while preventing, if possible, further deterioration.

The counselor needs to be sensitive, patient, observant, and able to listen and anticipate reasons for a client's response. An angry, insulting client living in a dangerous situation may be a very frightened person. A victim of physical abuse may try to avoid further mistreatment by denying the abuse has occurred. A client who is being sexually abused may relate details of what is happening to someone else or exhibit behaviors which are indicators of abuse occurring. The counselor will need to be on the alert for signs of abuse, neglect, or exploitation.

When the counselor has established a meaningful relationship with the client, there is a greater possibility that the situation may be evaluated accurately. If the counselor-client relationship is new, pressure to take immediate action may impede efforts to gain the client's trust – either due to demands from relatives and/or the community for immediate action to resolve the client's problem or due to the urgency of the client’s precarious circumstances. To the extent possible, these pressures should be resisted as a better result for the client can be obtained after trust has been established.

Appendix F
SERVICE PROVISION PRACTICE GUIDE

If the Department determines that an adult is in need of protective services, it shall provide or arrange for the provision of the appropriate services except in cases in which the adult chooses to refuse such services.

Consent of the client may be given in various ways ranging from outright acceptance to reluctant acceptance with much reservation and misgiving. Casework and interviewing skills will be required when reluctant acceptance is voiced in order to obtain the participation and cooperation of the client. In such cases efforts to provide needed service should continue unless the client makes a definite decision to withdraw consent.

In almost all cases APS is able to provide services to clients without seeking any sort of court action. Legal action is only used in severe cases as a last resort and after all other reasonable efforts have been made and documented. Legal Policy - Chapter 11

Most persons in need of protection can be adequately served through the efforts of APS social counselors who establish good client-worker relationships, accurately evaluate the needs of the client, seek and use the help of interested relatives and friends, and effectively use community resources including contract agencies.

Provision of services will be based on the identification of the crisis and vulnerable domains on the safety assessment. An action plan will be auto-generated following the completion of the post safety assessment/outcome measurement.

APS Counselor's Actions and Activities

During the course of an investigation or at any time throughout the life of an APS case, actions taken by the APS counselor in an effort to reduce or eliminate identified risks may be considered as an informal service (*i.e.*, efforts to persuade a client to accept services, working with a client to develop a safety plan and giving a client information about resources, etc.).

Safety Plans

Clients who are assessed as living in dangerous circumstances in which abuse / neglect or self neglect has occurred or is likely to occur can be helped in several ways. Determine the client's willingness to make changes and what he / she wants to happen. It is common for victims to feel helpless, confused and guilty.

The client may, therefore, need a great deal of support in making positive changes, and changes may occur as a slow process.

Removing Alleged Perpetrator in Instances of Abuse / Neglect

This is especially appropriate when the home belongs to the client. Discuss options with the client which may include:

- Commitment of a mentally ill perpetrator;
- Protection Order Legal – Spousal Abuse / Domestic Abuse;
- Refusing to allow perpetrator into home and calling the police;
- Arranging for the perpetrator to see the client when others are present; or
- Identifying other sources of care for the client when the perpetrator provides critically needed care but is also abusive.

Removing Client from Situation

In situations in which the client needs to leave or be removed from the abusive arrangement, considerations may include:

- Assistance in finding other places to live (with relatives, friends, shelters, etc.),
- Assistance in obtaining special care or supervision (residential homes, nursing homes, foster homes, etc.), or
- Court intervention to make DHS the decision-maker with court authority regarding placement.

Clients Who Choose to Remain in Abusive Situations

A client who is capable of making his / her own decisions regarding his / her living arrangement may decide to maintain the relationship with the perpetrator. In these cases the role of the APS Counselor is to support and encourage the client in taking action(s) which will reduce his / her risks. One method of reducing risk is to help him / her develop a "safety plan" for the specific situation. The plan may include the following:

- how to get out of the house,
- a safe place to go,
- a signal with a neighbor alerting him / her to the client's danger (a certain light turned on),

- changed locks,
- call 911 when abuser is on premises,
- file for an Order of Protection,
- add "Caller I.D." to telephone,
- discuss and identify behaviors of the abuser which are exhibited prior to an abusive incident and help the client increase his / her awareness of these patterns,
- have an escape bag and plan for how the client will respond when he / she feels threatened,
- plan a way to have access to some funds if temporary shelter is needed,
- maintain or increase contact with family or friend(s) and confide in someone about the situation (do not allow isolation to increase),
- identify others the client may want to have check on him / her, and
- identify alternatives for obtaining needed care when the abuser is the caretaker and is violent.

Adult Day Care

Day care for adults may be considered if the safety of the client can be contained or controlled by having activities and supervision for the client provided outside the home for part of the 24-hour day. There are currently licensed Adult Day Care programs in the State. DHS, Child Care Division, provides licensure for Adult Day Care.

Most adults who attend an Adult Day Care are private pay with a few adults receiving assistance with the cost of care. DHS contracts with several Adult Day Care providers to provide services to APS clients and non-APS clients. This funding is through the SSBG grant and is only available in some areas. APS clients are eligible for partial funding without regard to income. Some Adult Day Cares are funded through the CHOICES Program.

Individuals who are not APS clients may receive partial funding for Adult Day Care through SSBG grant funds if they are income eligible (at or below 125% of the poverty level). Each provider will have its own application process.

For APS clients to receive partial funding for Adult Day Care, APS staff must do the following:

- Make referral / application to an Adult Day Care from a list of contracted agencies.

- Complete an Authorization Form (567) and submit to the Adult Day Care and Community Services state office.

Adult Day Care can only be provided through SSBG to APS clients with an open case. When the APS case is to be closed, APS staff must do the following:

Complete a Form 905 Termination of Services and submit to the Adult Day Care and Community Services state office. Closing an APS case does not necessarily mean that the adult must leave the Day Care program. The client can no longer attend as WRI (without regard to income), but could continue participation if he / she qualifies and is able to pay the fee required for income-eligible participants.

Counseling

The APS counselor may play a critical role in helping to resolve family conflict and in pulling together concerned family members who may assist in providing care or protection for the APS client. When the client's problems include seriously strained relationships with others who play an important part in his / her life, consideration should be given to whether counseling by APS staff or referral to a mental health center may help the persons involved. They may need help in understanding each other, adapting their behavior to an acceptable pattern, learning to be tolerant of the situation, or learning to let go and accept help from others.

In-Home Services

If danger for the client is identified and found to be a real threat to the client's well-being and it is determined that the client is in need of protection, then consideration must first be given to the possibility of providing that protection in the client's own home. Such protection may be possible through any one or a combination of the following: medical care, mental health treatment, homemaker services, day care, financial management, chore services, and home-delivered meals or other services. These and any other available resources should be considered as methods of relieving the danger in which the client is found. For more information on services and programs providing in-home services, see sections on the Department of Human Services and the Commission on Aging and Disability in this Practice Guide.

Interpreters / Translators

In the course of investigating or providing services to APS clients, it is not unusual to encounter clients who, as a result of the aging process or through illness, are deaf or hard of hearing, or have other disabilities that affect

communication. Successful communication may also be hindered if the individual is non-verbal or has limited English proficiency (LEP). Many of these clients have not learned alternative ways to communicate and must depend on relatives or other caretakers to provide information for them. To insure that these clients are being afforded the opportunity to make their needs and circumstances known, APS counselors should make available a certified interpreter rather than a relative or caretaker, especially during an investigation or when assisting the client to obtain medical care.

Qualifications / Confidentiality

All interpreters / translators whose services are used must possess the necessary qualifications and fluency to thoroughly and accurately communicate with Adult Protective Services clients and any other individuals who may be needed during the investigation or provision of services. They must be bound by a professional code of ethics that requires confidentiality and must maintain confidentiality as required in the Tennessee Adult Protection Act.

Arranging For an Interpreter / Translator:

Services for Deaf and Hard of Hearing

It is the responsibility of the Tennessee Registry of Interpreters for the Deaf to compile and update annually a list of qualified interpreters for those who are deaf or hard of hearing and to make this list available to DHS legal staff.

APS staff should refer to and select a service provider from this list. For persons who are unable to speak or write due to illness, medical or mental condition or accident, and who require the use of persons capable of interpreting, DHS will determine, based on experience and education, who should be utilized as a resource.

TTY

When communicating by telephone with someone who is deaf or hard of hearing and who has a text write telephone, APS staff can utilize TTY (teletype writer) services. There is no charge for the service in Tennessee other than customary telephone charges. The number is 1-800-848-0299.

This number will access a relay operator who will convert the caller’s voice message into a text message for the deaf / hard of hearing person, and convert the typed response into a voice message. Telephone relay operators are bound by confidentiality.

Translation Services for Regarding Limited English Proficiency

For communication with persons who have limited proficiency in the English language (LEP), the services of a translator may be needed. APS staff has access to translation services that are provided by a statewide contract for state agencies to ensure compliance with Title VI. The translation service is accessed by telephone and can be used by APS staff to translate face-to-face as well as telephone conversations. Below is information on the current vendor for phone based language interpretation: To use the service, follow the instructions below:

NUMBERS TO DIAL TO ACCESS AN AVAZA INTERPRETER

(615) 534-3405 – Nashville area
(901) 257-3190 – Memphis area
(865) 342-7768 – Knoxville area
(731) 410-2911 – Jackson area
(931) 472-0446 – Clarksville area
(423) 424-0950 – Chattanooga area

If you are outside of the local calling area of any of the above cities, then call 800-482-8292

You will need the Client ID Code for the Department of Human Services.

You will need the APS Access Code.

Accessing Avaza can be done in the following ways:

1. When the LEP person is present at your location.

    a. If the LEP person is present with at your location, dial the assigned AVAZA number.
    b. Be ready to provide your access code, the DHS client ID, your name, and the language that you are requesting.
    c. Provide the information above and you will be connected to an interpreter.

2. When the LEP person is on the telephone with you.

    a. If the LEP is on the telephone with you, place them on hold and dial the assigned AVAZA number.
    b. Be ready to provide your access code, the DHS client ID, your name, and the language that you are requesting.
    c. Provide the information above and you will be connected to an interpreter.
    d. Once you have the interpreter on the line, conference in the LEP, yourself and the interpreter. If you do not know how to use your conferencing feature on your telephone, please contact your telephone administrator.

3. **When you need to contact the LEP and conference in the interpreter.**

    a. **If you need to contact the LEP person at home, dial the assigned AVAZA number.**
    b. **Be ready to provide your access code, the DHS client ID, your name, and the language that you are requesting.**
    c. **Indicate that you need to perform a "call out" (understand that you have the LEP person's contact number).**
    d. **Provide the LEP person's contact number and AVAZA agents will call that number and conference in all parties.**

Katherine Rebolledo, Senior State Manager, k.rebolledo@avaza.co (615) 534-3404

Melanie Velazquez, Senior State Manager, m.velazquez@avaza.co (615) 534-3403

RELATIVES AND FRIENDS

If a client is unable to act in his / her own behalf, help from responsible relatives or other appropriate persons should be sought. Their help with planning and their moral support are usually needed by the client. In many cases family and/or friends will be able to meet some of the client's needs and the Department's role will be to provide guidance and support to those helping the client.

The Department of Human Services is to assist the client if there is no other available, willing and responsibly able person to do so. However, the presence of family or other individuals in a client's life does not prevent APS intervention or APS assistance with the provision of services nor will it prevent the acceptance of a referral or the investigation of allegations.

In some cases no services from DHS will be needed. It is critical to have empathy for the families and friends of mentally and/or physically disabled clients who are trying to help the client. Those who try to help may fall short of what others (including the client) expect. APS recognizes the burden of caring for a friend or family member. There are many demands on the person's time and money. There are guilt feelings from not being fully able to take care of the situation. There are often bad feelings due to a lack of understanding or incorrect information. In such cases the APS role will be one of support and encouragement, in order to best serve the client's needs. The APS counselor must, however, avoid taking over the vital role of families and friends.

Out of Home Placements

Emergency Placement Services

In the past, APS Family Homes for Adults was the only resource for an APS client who could not live alone or with relatives and who did not need nursing home or institutional care. With Family Homes for Adults not available statewide, the inability to meet the emergency placement needs of APS clients has been a major obstacle to securing the protection that is needed. Now, under certain circumstances described below, limited funds will be available for securing a short-term emergency placement including after-hours, on weekends/holidays, or until more appropriate arrangements are available to meet the safety and supervision needs of the APS client.

Under certain circumstances described below, limited funds will be available for securing a short-term emergency placement including after-hours, on weekends / holidays, or until more appropriate arrangements are available to meet the safety and supervision needs of the APS client.

Licensed community service providers that have agreed to provide short term emergency services either in home or out of home may be utilized as outlined below:

Who qualifies for Emergency Services – aged or disabled adults in need of protective services from DHS-Adult Protective Services

(1.) who do not meet criteria for hospital/nursing home placement but are unable to meet their needs without supervision and/or assistance and who have no safe place to stay on an emergency basis; and/or

(2.) who are at risk of A/N/E and who have no safe place to stay on an emergency basis until appropriate arrangements are secured may be served by these funds.

Service provider selection – Authorization for emergency services will be made only with an entity licensed by the state to provide such care (hospital or nursing home) or an entity licensed by the state to provide such care in an in-home setting (home health agency or sitter service). Emergency Services will be based on a prorated flat rate per twenty-four hours of care by the licensed entity.

A service provider agreement letter between the APS unit and the licensed entity will acknowledge the terms of the service and document the flat rate per twenty-four hours of care agreed upon. This rate cannot exceed $200 per twenty-four hours of care and should be negotiated by the APS Field Supervisor below the

maximum rate if possible. This is a daily rate, not an hourly rate. So, if the vulnerable adult needs care for 5 hours, negotiate a flat rate for the 5 hours.

The letter should also detail that state funds are the payment source of last resort and that the individual's resources are the primary source of payment.

The Service provider secures payment from the individual's insurance resources/APS Emergency Services funds not utilized - When a vulnerable adult has received treatment at an ER/hospital and no longer meets medical criteria for treatment but there is a concern that releasing the person will place them at risk of harm by someone who might abuse, neglect or financially exploit them, or that the risk of harm is due to their inability to care for themselves, there are two codes the facility can use to keep them safe until APS can respond and the cost of care may be covered by the patient's insurance. The treating physician **has to note in the patient's medical record** the need for continued services by the facility based on one or both ICD9 codes (this coding system is used by most of the facilities in Tennessee) and the facility's coding/billing department submits their documentation to the insurance provider using the following ICD9 codes:

V71.81 - Used for "observation and evaluation for other specified suspected conditions: abuse & neglect".

V15.81 - Used for self-neglect situations - "Non-compliant with medical treatment".

NOTE: Due to the limited funds, this option must be explored first prior to utilizing the short-term APS Emergency Services funds.

Payment procedures for APS Emergency Services funds –State funds to cover the cost of Emergency Services are very limited and will require prior approval by the APS State Office before they are committed.

If the program supervisor and the field supervisor determine that emergency services need to be utilized, the FS1 should contact state office by telephone. The Director or designee will approve the use of emergency funds for 5 calendar days unless the 5th day falls on a Saturday or Sunday. Then, the approval will be through that following Monday. The FS1 will provide the cost per day to the Director/designee during this call. The FS1 will follow up with a email to the director or designee.

No later than the next business day, the FS1 or social counselor will complete the APS Emergency Service Provider Agreement and will have the original signature of the service provider contact. The form must be filled out in its entirety and all signatures obtained except state office. None of the signatures

have to be original except for service provider contact. This means the form can be faxed / scanned to the FS1 and PS and they can sign it and scan it back to the social counselor. The social counselor will attach a copy of the agreement to the client's case in the APS automated system. The SC will fax / scan the completed form to State office and will mail the original to state office. This MUST be completed no later than the next business day – no exceptions.

If after 5 calendar days, the social counselor still requires use of emergency funds, the field supervisor must contact the director or designee by email to request an additional five days and provide detail as to what steps the FS1 or SC has taken to secure the vulnerable adult's safety. This will continue every 5 days not to exceed 31 calendar days for any one vulnerable adult. There is no exception.

The social counselor is responsible for completing the Emergency Services Invoice and getting all signatures except state office signature. The Vendor # is the Edison ID number for the agency that was used. If the agency doesn't have an Edison ID number, then the agency will need to complete the substitute W-9 form (2 pages). It is the social counselor's responsibility to provide these forms to the agency that was utilized. The social counselor can obtain these forms form APS state office staff. The agency must submit an invoice to the social counselor.

The social counselor is also responsible for completing the authorization to vendor form and getting the service provider's original signature on the form.

The service provider must submit an invoice.

If services were utilized in two different fiscal years for the same client then each month has to have its own set of forms.

For Example: SC accessed emergency funds in June 2012 for client John Smith. This would require a submission of forms for the month of June. Then, SC accessed emergency funds in July 2012 for client John Smith. This would require a separate submission of all forms for the month of July.

The fiscal year runs from July 1 of the current year to June 30 of the next year.

Even if funds are accessed for the same client in different months, APS can only utilize 31 days total for any one client.

All the **original forms** are to be mailed to the state office no later than 1 month from the last date the service was utilized. The FS1 or designee are responsible for making sure the forms are submitted timely and filled out completely before submitting to state office. If the forms are not filled out completely, they will be returned for correction. This will cause a delay in payment to the service provider.

Do not submit these forms separately. One submission should include the authorization to vendor, emergency services invoice, substitute W-9, and the agency's invoice. The social counselor is responsible for putting copies of these items in the electronic case file for that vulnerable adult.

It is not the responsibility of state office to negotiate the rates. It is not the responsibility of state office to complete the forms. State office is responsible for submitting the forms to DHS Fiscal for payment.

Hospitalization

There may be times when the client's physical or mental condition indicates a need for medical care, including hospitalization. The Diagnostic Related Group (DRG) is a uniform code for reimbursement used by hospitals to categorize patient admissions. In some situations, the client may be able to receive care as an outpatient, or the hospital is ready to discharge the client, but there is no safe placement immediately available. It may be possible to use an appropriate DRG to gain admission to the hospital or extend the client's stay for a limited period to allow enough time for the APS counselor to arrange for an appropriate resource or implement an intervention to ensure the client's safety.

It is important for APS staff to be aware of this option and of codes that may be used to permit the client's hospital stay so that staff:

- will recognize hospitalization as an option for temporary safety;
- may be able to knowledgably discuss this service with medical staff as part of planning for the client's safety.

Following are some of the codes that can be used to admit clients from unsafe environments:

- **"Adult Maltreatment Syndrome"**
    - DRG # 454 – Ages 70+, injury/toxicants with complications
    - DRG # 455 – Ages 18 to 70, without complications
- **"Decubitus Ulcer"**
    - DRG # 271 – Skin ulcer, multiple etiologies
- **"Malnutrition"**
    - DRG # 296 – Age 70+, with complications
    - DRG # 297 – Age 18 to 70, without complications

There may be other DRGs that are applicable to gain temporary hospital admission for the client's safety.

Nursing Home Placements

Third Party Signatures

A nursing home cannot require a third party signature as a condition for admission to the facility for a Medicaid or Medicare recipient. A nursing home may require a third party signature for private pay patients. Also, any person appointed by a court to serve as the conservator or guardian of an adult may be required to sign the application for admission. Most nursing homes will request information regarding the patient's next of kin and/or the person to contact in the event of an emergency. However, obtaining this information is different from signing an application for admission and assuming financial responsibility.

When the Department has custody of a client who is placed in a nursing home or other long-term care facility, the counselor cannot sign any form(s) which would make the Department financially responsible for the costs of the client's care. At the custody hearing, a **temporary guardian** may be appointed to handle the client's finances for the purpose of providing such care. T.C.A. § 71-6-107(a) (6)

If the counselor is unable to convince staff of the nursing home that a third party signature is not required for a Medicare or Medicaid recipient, the Long-Term Care Ombudsman or the Patient Care Advocate may be able to assist with this problem.

Nursing Home Waiting Lists

This information on nursing home waiting lists pertains specifically to nursing care facilities that participate in the Medicaid program. Nursing homes are required to maintain a waiting list of persons requesting admission to the facility. The waiting list must include the applicant's name, address, telephone number (if any), sex, race, date and time of application, and the person or agency referring the applicant to the facility. Generally, admissions to nursing homes are made in the order the referrals were received. Deviations from the order of application may be made when the deviation is based on medical need or other exceptions approved by the Department of Health. The nursing care facility will have a letter from the TN Department of Health indicating approved deviations.

Caution must be exercised when requesting an "emergency" placement which requires by-passing other applicants to a facility. Adult Protective Services counselors need to guard against becoming a community funnel for expedited access to nursing homes. However, APS clients in dangerous circumstances can legitimately benefit from this exception.

Relocation

Our focus is on protecting the client and in order to do this we must:

- determine the level of care the client requires and
- help the client to understand and accept this level of care.

If it appears that the client needs to move to a different living arrangement due to dangerous physical surroundings, an abusive caretaker or the need for additional care and/or treatment, then it is essential that the client consent. Without the client's consent, a move can be made only by court order. An involuntary move is more traumatic for the client than one which is understood and accepted.
Many times a client will refuse a new idea out of fear or lack of understanding. They may fear a change because they do not know what will happen to them or they may have been given misinformation about a possible placement. In order to encourage change APS must deal with the client's fear. A visit to the proposed new residence is often helpful. A chance to see the new location and talk to others without being obligated to stay or to return if they do not want to stay may help.

When relocation is being considered, the anticipated effect upon the client must be weighed very carefully against the satisfaction the client may feel in remaining in familiar but dangerous surroundings. A client who is capable of understanding his / her situation may make the decision to continue living in a residence which APS believes to be unsafe. Even if the client agrees to move to another location, a successful move is not guaranteed. The new arrangement may not be all that the client expected; there may be more regrets than anticipated over leaving the old residence; and relationships with others in the new setting may be disappointing, etc. However, some moves are more successful than the client may have expected. They may find the adjustment easier and find greater security in the new location.

Some clients are more appropriate for Adult Family Homes than nursing homes while others require nursing home care. Foster care, as provided in a family setting, is quite different from that of an institution. Many elderly and disabled persons look upon moving into a nursing home, not as achieving care and protection, but as loss of control over their own lives, possibly even a threat to survival.

Also to be considered is the client's ability to cope with change. Keeping in mind that, if the client is traumatized by the change, the reaction may be intensified if the client also feels that he / she has no control over what is happening. It is, therefore, important to support and encourage the client's participation in placement decisions to the greatest extent possible. If a client with the capacity to understand and make decisions and in need of relocation refuses despite the APS counselor's best efforts, then APS will continue to provide whatever services the client will accept that serve to reduce risk.

Relocation to Unlicensed Facilities is Prohibited

The counselor cannot assist the client in moving to an unlicensed long-term care facility or in violation of licensing requirements. The Tennessee Department of Health has the legal responsibility for the licensure and regulation of long term care facilities. If APS assisted in placement of a client into an unlicensed facility, APS would be aiding in the violation of the law. Furthermore, the provider of care might feel compelled to accept the client if DHS staff were involved with the placement. They could then be operating in violation of the licensing law. Staff must, therefore, check that any new facility being considered is licensed and this can be accomplished by contacting DOH.

The counselor may need to assist adult protective services clients or their caretakers in locating and/or making application for admission to licensed long-term care facilities.

Law Enforcement Cooperation with DHS T.C.A. § 71-6-115

Law enforcement officials are required by law to cooperate with the Department of Human Services in the provision of protective services. Further, when DHS has a client in custody and that client leaves a placement unauthorized and APS is unable to return the client to the placement, law enforcement is required to assist in returning the client to the placement and is required to give priority in providing such assistance.

Tennessee Bureau of Investigation (TBI)

The TBI Medicaid Fraud Control Unit (MFCU) uses a diverse team of Special Agents, a Managed Care Program Manager, attorneys, auditors, nurses, programmers, statistical analysts and secretaries to protect the tax payers of Tennessee against fraud. Members of this team are based throughout the State.

The MFCU conducts a statewide program for investigating and referring for prosecution violations of all state and federal laws pertaining to fraud in the administration of the Medicaid program as well as abuse and neglect of patients in health care facilities receiving payments from the Medicaid program or in group homes.

MFCU staffs are involved in training a wide variety of groups on topics such as what fraud is and how to detect and report it. They also meet with officials from TennCare, the Attorney General's Office, Commerce and Insurance, Cigna (Medicare carrier) and Health Related Boards on a regular basis to exchange information on overlapping issues.

Representatives of the MFCU comprise an integral part of the Nursing Home Abuse and Neglect Working Group. The Working Group has set goals to create a better and more consistent referral system and a method for all representative agencies to better communicate and cooperate.

The MFCU investigates PROVIDER FRAUD. A provider is any business or individual that supplies medical services to TennCare recipients. Providers can be medical doctors, dentists, hospitals, nursing homes, pharmacies, or anyone else who bills a TennCare MCO for medical services provided to a TennCare recipient. To put it simply, a provider commits provider fraud by lying to obtain an improper payment for services rendered (or supposedly rendered) to TennCare recipients. The result is an increase in the cost of the TennCare program that gets passed along to the taxpayers. A list of examples appears below:

- Billing for medical services not actually performed
- Billing for a more expensive service than was actually rendered
- Billing twice for the same medical service
- Dispensing generic drugs and billing the MCO for expensive brand-name drugs
- Kickbacks-giving or accepting something in return for medical services
- Abuse or neglect of patients in facilities receiving funds from TennCare
- Bribery

Tennessee Commission on Aging and Disability (TCAD)

Information and Referral (I&R) Hotline

The Information and Referral (I&R) program is a way to connect people to health and human services needs, as well as provide information of a more general nature. When an individual is uncertain about available and necessary services, he / she can describe what is happening to him / her and receive information to guide him / her in a direction best suited to his / her individual situation.

I&R specialists, on the community level, help a caller find out what is needed and then the best way to get the help. They are trained to determine whether a caller may be eligible for certain programs, to help in crisis situations, and provide extra

help when needed. With the right information people can often solve their problems and improve their lives! A quick way to locate services in your community is to call the Eldercare Locator at 1-800-677-1116 or the TENNOPT line at 1-866-836-6678. A good source of information is the Resources section on the Homepage of the website, http://www.tn.gov/comaging/resources.html

Before contacting an I&R specialist, or using an online I&R database, be prepared to write down the information that is provided to you. You may be asked to answer a few questions about your client, such as; address family support, income level, etc., in order to assist in finding the right program for your client's particular needs. I&R services provide free and confidential information and will not share any personal information that you provide.

Congregate Meals

Congregate meals are served in group settings and are provided in nutrition centers across the State. Meals may be served at various sites, such as, senior citizen centers, schools, churches, community centers, and other types of locations. The nutrition centers in each county provide, in addition to a meal, opportunities for socialization, and participation in program activities. Services that are planned at nutrition centers include meals, nutrition and health promotion education, recreational activities, shopping assistance, transportation, counseling, information and assistance, health screening and many other innovative activities. The centers operate Monday through Friday except for holidays.

Home Delivered Meals

Because of the interdependence between a person's mental and physical conditions, treating one area may have positive effects on the other. Improvement in the physical condition frequently results in improvement of the mental condition. Reviewing a client's activities, nutrition and medication is important in assessing his / her needs. A referral to a home-delivered-meals program may bring about improvements in both physical and mental functioning.

There are three programs that offer home delivered meals:

1. Title III-C of the Older Americans Acts provides in-home assistance for the elderly through the Home-Delivered Meals program.

   Eligibility requirements include meeting all of the following:

   - 60 years of age or older
   - Homebound
   - Must have NO household member able to prepare meals

- Must have a minimum of (2) two ADL's and a total ADL/IADL score of at least six (6)

2. State Funded Home and Community Based Services, OPTIONS, offers home delivered meals.

   (See "OPTIONS" section in this Practice Guide for more information.)

3. The CHOICES Program for Home and Community Based Services, "The CHOICES Program," offers home-delivered meals.

   (See "CHOICES Program for HCBS" section for more information in this Practice Guide.)

Homemaker Services

There are four (4) government programs that offer homemaker services. These programs are designed to provide in-home assistance with household activities. Homemaker services are limited to in-home personal care services designed to allow a participant to remain in his / her own residence and maintain independence.

Homemaker services may include:

- menu planning,
- maintaining a safe environment,
- budgeting,
- shopping,
- meal preparation,
- general household management and
- light housekeeping.

Routine light housekeeping duties may include, but are not limited to:

- sweeping,
- mopping,
- dusting,
- vacuuming,
- cleaning kitchens and bathrooms,
- changing linens,
- making beds,
- laundry,
- ironing,
- mending,
- preparing meals, and/or
- education about the preparation of nutritious, appetizing meals.

The four (4) governmental programs are:

1. The Protective Service Homemaker Program is funded through a grant from the federal Department of Health and Human Services. The Social Services Block Grant (SSBG) Program administered by the Department of Human Services provides funding for the Adult Homemaker Program, referred to as the "Protective Service Homemaker Program," through contracts with an established network of 15 non-profit agencies and local governments. There is no fee for this service, and it is provided without regard to income or age. Referrals are made by APS staff by completing the Homemaker referral form and Authorization Form 567. (See section on APS Homemaker Program in the Department of Human Services section for additional information.)

2. Title III-B of the Older Americans Acts provides in-home assistance for the elderly through the Homemaker Program. In addition to the following eligibility requirements, income guidelines for this program do apply:

    - 60 years of age or older
    - Must have NO household member able to provide the service in order to qualify
    - Must have a minimum of (1) one IADL limitation and a total ADL/IADL score of at least three (3)

3. State-funded Home and Community Based Services, OPTIONS, offers homemaker services. (See section on "OPTIONS" in this Practice Guide for more information.)

4. The CHOICES Program for Home and Community Based Services, formerly known as "The Waiver Program," offers homemaker services. (See section on the "CHOICES Program for HCBS" in this Practice Guide for more information.

Long-Term Care Ombudsman

The nine (9) Area Agencies on Aging contract for a Long-Term Care Ombudsman. Ombudsmen are located in Johnson City, Knoxville, Chattanooga, Cookeville, Columbia, Nashville, Martin, Jackson and Memphis. The Ombudsman works with patients and their families facing barriers to long-term care. These adults may be in nursing homes, as well as board and care facilities. The Ombudsman can play an integral and vital role with the DHS counselor and the Adult Protective Services client, because of their ability to investigate and resolve complaints made by and on behalf of older persons who are in long-term

care facilities. They are able to work with clients on concerns relating to administrative actions which may adversely affect their health, safety, welfare and rights.

The Ombudsman is able to address various problems faced by residents of long-term care facilities ranging from unsatisfactory food; unexplained extra charges; involuntary transfers; discharges predicated on source of payment or changes in level of care; discriminatory practices at admission; and early release from hospitals due to DRGs (Diagnostic Related Groups) and the placement problems of the client not well enough to return home. The Ombudsman should be contacted when he / she can provide assistance with problems or concerns related to a client in a long-term care facility. The Ombudsman should be notified of any abuse / neglect / exploitation issues occurring in a facility by receiving a form 1215 from APS staff. Click on this link http://www.state.tn.us/comaging/ombudsman.html for a list and more information on the Ombudsman Program.

National Family Caretaker Support Program (NFCSP – Title III-E)

This program is designed to help persons who are providing assistance to an elderly person (family caretaker) and thereby prevent or delay nursing home placement of the elderly person. All services are designed to ease caretaker burden and provide needed support to unpaid caretakers. This program provides:

- Information about services
- Assistance in gaining access to supportive services
- Individual counseling, support groups and training
- Respite care for temporary relief of caregiving responsibilities (respite sitter, respite personal care, respite homemaker)
- Supplemental services which are based on individual need include home delivered meals, Personal Emergency Response System (PERS) medical equipment / supplies, assistive technology purchases.

The program includes help with training and counseling for the caretaker and in-home supportive services for the care receiver. A caretaker does not have to live with the recipient to be eligible for this program. Care recipient must be over 60. Call 1-866-836-6678 to make a referral.

Public Guardianship for the Elderly Program

The Public Guardianship for the Elderly Program was established in 1986 by the Tennessee General Assembly. The primary purpose of the program is to provide conservatorship services to persons sixty (60) years of age and older, who are unable to manage their own affairs, and who have no family member, friend,

bank or corporation willing to act on their behalf. This service is available in all 95 counties of the State, through the district public conservators located in the nine (9) Area Agencies on Aging. As a less restrictive measure, power of attorney services may also be offered by the local programs.

The clients served through the district public conservatorship programs must be unable to make decisions regarding their finances or needed medical care. Frequently they need assistance in obtaining the basic necessities of life. District public conservators help clients by providing assistance which enables them to remain in the least restrictive environment, while preserving personal dignity.

There are no charges for the services provided through the Public Guardianship for the Elderly Program. However, the court may award a fee to the program whenever the resources of a client indicate this to be appropriate. In no instance does a client who meets SSI low-income standards pay a fee. When the services of the Public Guardianship for the Elderly Program are deemed appropriate by the District Public Conservator, an application form will be required prior to acceptance into the program. The form is completed by the person who is requesting the service. Click on this link for more information on the Public Guardianship Program. http://www.state.tn.us/comaging/guardianship.html

Medication Management

This service is available through contracts with Tennessee Commission on Aging and Disability and is authorized under Title III-D of the Older Americans Act. The program is designed to provide medication management, screening, and education to prevent incorrect medication use and adverse drug reactions. This program offers a registered nurse who is available for group presentation and/or individual counseling on medication issues such as medication regimen, proper storage, potential interactions, managing side effects, compliance aids, safety precautions, and individual concerns. Call 1-866-836-6678 to make a referral.

CHOICES - Home and Community Based Services

This service is available through the Managed Care Organization (MCO) of Tenncare. This program is designed to be an alternative to nursing home placement. Approved by the Centers for Medicare and Medicaid Services (CMS), this program is designed to provide functionally impaired adults with a community based cost-effective alternative to institutional nursing facility care. As with nursing home placement, estate recovery may apply since this program is also funded by Medicaid.

Thirteen (13) services are available:

- Case Management
- Home Delivered Meals
- Homemaker Services

- Personal Care Services
- Minor Home Modifications
- Institutional Respite
- Personal Emergency Response System (PERS)
- Personal Care Attendant
- Pest Control
- Assistive Technology
- Assisted Living
- Adult Day Care
- In-home Respite

Eligibility requirements are:

- Live in Tennessee
- Age 21 or older
- Have an identified caretaker
- Be financially eligible for Medicaid
- Meet Medicaid criteria for payment of level one nursing home care
- All needs must be safely met safely with CHOICE'S services
- Annual cost of home care from all sources must be less than annual cost of nursing home care

Call the client's MCO or 1-866-836-6678 to make a referral.

State Funded Home and Community Based Services (HCBS), OPTIONS Program

This program is intended to provide in-home assistance to functionally-impaired adults to enable them to remain independent in their own homes and communities with an enriched quality of life. There are three (3) services available:

- Personal Care,
- Homemaker services, and
- Home-Delivered Meals.

Eligibility requirements are:

- Must be age 18 or older and have limitations as follows:
    - For personal care must have a minimum of (1) IADL and a total score of (3) for ADL/IADL
    - For homemaker services must have a minimum score of (3) for ADL/IADL

- For home delivered meals must be homebound and have a minimum ADL/IADL score of (6)

Quantity and type of services depend on individual needs and availability of services. In-home assessments are required every 6 months. All services EXCEPT MEALS are subject to a cost share depending on income.

APS active cases have priority for the OPTIONS program.

Rx Assist

This is a free service to assist people to obtain necessary medications that they are unable to afford. Call 1-866-836-6678 to make a referral.

State Health Insurance Assistance (SHIP)

This program provides free and objective counseling and education on Medicare and other health insurance issues. Call 1-866-836-6678 to make a referral. Visit http://www.state.tn.us/comaging/ship.html for more information.

Tennessee Department of Human Services (DHS)

There are services within DHS that may be accessed in order to assist the APS client. They are as follows:

APS Homemaker Program (Protective Services Homemaker Program)

Because protective service homemaker slots are so limited, staff may want to consider other programs before making a referral for a protective services homemaker. If the APS client is in crisis or in extreme need, a referral should be made to the program that is able to respond in the timeliest way.

Prior to authorizing protective services homemaker services for a client, a careful evaluation of the client's needs is necessary. A complete understanding of the client's abilities, as well as present limitations, is critical in making appropriate requests for homemaker services.

Generally, a homemaker may assist in situations in which the client is unable to perform critical household tasks. The homemaker may assume responsibility for light cleaning, planning and preparing meals, shopping, light laundry, and simple bedside care. If the client is able to perform some household tasks, the homemaker will perform those which are specified by the counselor and cannot be completed by the client. If the homemaker observes that the client is not able to perform some other tasks or if the client refuses to do what seems reasonable

for him / her to do, the problem should be brought to the counselor's attention. The plan for the client may need to be adjusted.

The homemaker cannot administer medication, change dressings, give enemas or irrigate catheters, assist with physical therapy or speech therapy, assist the person in or out of the tub or shower, etc. The homemaker can remind the client to take prescribed medication on schedule, assist with personal grooming, assist with bed baths, assist in walking to the bathroom, assist into a wheelchair or other chair, feed the client, etc.

A referral for homemaker services is not appropriate when the only service needed is transportation. Most homemaker providers do not provide transportation. Those homemaker programs that do provide transportation do so only in conjunction with other activities which are appropriate under homemaker services.

A homemaker referral may be considered in cases such as:

- an elderly client living alone who is no longer able to manage some of the basic household tasks;
- a disabled client who may be dependent on a neighbor to provide needed care and the neighbor moves without notice, becomes ill or dies, or refuses / is unable to continue assisting the client;
- an ill or infirm client who is waiting on an appropriate placement (example: residential home for the aged);
- a stressful situation created in a family caring for an infirm client has led to neglect or abuse, and having a homemaker accept some responsibility for the care of the client provides needed relief;
- an elderly client may have lost a spouse and needs training from the homemaker on ways to take care of his / her own needs (example: food preparation)

A counselor requesting homemaker services must be specific as to the tasks the homemaker needs to perform. The client needs to do as much for himself / herself as possible, while the homemaker supplements what the client, the family and/or friends are able to do. To the extent possible, the client needs to be included in the assessment process.

APS and Homemaker Services

When assessing a client's need for Homemaker Services, keep in mind that the client must meet the criteria for receiving protective services before a protective service homemaker can be assigned. Not everyone who would benefit from a homemaker is in need of protective services. It is not appropriate to have a

homemaker accompany the counselor to initiate the investigation. Prior to authorizing homemaker services, the case must be fully assessed as to risk, client functioning and available support systems.

After carefully identifying the needs which can be met by the homemaker, the counselor should clearly convey this plan to the homemaker provider and assist in implementing the plan. The counselor must go with the homemaker to the client's home for the homemaker's initial visit. The counselor will continue to have regular contacts with the client to evaluate the services being provided. The counselor may need to:

- help the client avoid over-dependency on the homemaker,
- involve relatives / friends in the care of the client,
- monitor the progress or deterioration of the client's condition, or
- help the client accept the homemaker in the home.

It may be helpful for staff to review the Performance Standards for Homemaker Services in the DHS Community Services Programs, Policies and Procedures.

Low Income Home Energy Assistance Program (LIHEAP)

The LIHEAP Program is 100% federally-funded through a grant from the federal Department of Health and Human Services. LIHEAP provides funds to the states to help meet the utility costs of low-income eligible elderly and disabled adults. Click here for LIHEAP list.

Weatherization Assistance Program (WAP)

This program is 100% federally funded through a grant from the federal Department of Energy. This program provides funds to states to assist with the weatherization of the home of low-income elderly and disabled adults and families. Contracts with 18 non-profit agencies provide this service in all 95 counties. Applicants must meet low-income eligibility guidelines based on established federal poverty guidelines. Services include insulation, storm windows, caulking, and other related home improvement to reduce home energy costs and increase home energy efficiency. Click here for WAP list.

Vocational Rehabilitation Services

Vocational Rehabilitation (VR) is a federal and state funded program providing services to help individuals with disabilities enter or return to employment. It is designed to assist individuals of work age with physical and/or mental disabilities compete successfully in the work environment.

To be eligible for VR services, a person must meet specific guidelines related to a physical or mental disability that results in a substantial barrier to employment. Due to limited resources, Tennessee operates under a legally-mandated Order of

Selection and currently can serve only individuals with the "most significant disabilities." The Vocational Rehabilitation Counselor determines eligibility with the help of medical examinations, psychological examinations, vocational evaluations, and other diagnostic information secured by the agency to determine the nature and extent of the disability. Applicants who receive SSI (Supplemental Security Income) or SSDI (Social Security Disability Insurance) benefits based on disability or blindness are presumed to be eligible if they intend to go to work, but further diagnostic assessments may be required to determine if they will be able to receive services under the Order of Selection.

Some of these services may be based upon economic need and may require financial participation on the part of the client. The Department's Division of Rehabilitation Services recognizes the unique needs of individuals who are deaf or hard of hearing. Thirteen (13) Vocational Rehabilitation Counselors, who are specially trained to work and communicate with persons who are deaf or hard of hearing, provide services that enable their clients to enter, retain, or return to competitive employment. Services are individualized and depending upon a person's needs may include the following:

- Guidance and Counseling
- Vocational Training
- Post Secondary Education
- Interpreting Services
- Provision of Hearing Aids and Other Adaptive Devices
- Personal Adjustment Training
- Technology Services
- Job Placement
- Physical Restoration
- Information Referral

These Counselors are located in regional DHS offices across the state.
http://www.tennessee.gov/humanserv/st_map_trc_ttap.html

Vocational Rehabilitation Services are also available to help eligible adults who are visually impaired to successfully compete with others in entering, returning, or retaining employment. These services are coordinated by Vocational Rehabilitation Counselors who have been specially trained to work with clients who are blind or visually impaired. Services are customized to meet the needs of the client who plays an active role in developing an Individualized Plan for Employment and choosing services and service providers. Depending upon an individual's particular circumstances, the following services may be available:

- Guidance and Counseling
- Vocational Training
- Post Secondary Education
- Orientation and Mobility Training

- Independent Living Services
- Personal Adjustment Training
- Work Adjustment
- Technology Related Services
- Job Placement
- Medical, surgical, and hospital care needed to eliminate or reduce the effect of the visual disability; and,
- Information and Referral

Council for the Deaf **1-800-270-1349**

The Tennessee Council for the Deaf and Hard of Hearing (TCDHH) has the responsibility for ensuring that state and local public programs and services are accessible to deaf, hard of hearing, late deafened and deaf-blind citizens. TCDHH coordinates communication, information, public awareness, and advocacy services through six regional community service centers. The centers assist the Division of Rehabilitation Services by providing services that complement those offered by Vocational Rehabilitation staff. TCDHH strives to open new avenues which will lead to equal opportunities for Tennesseans who are deaf, hard of hearing, late deafened or deaf-blind. The centers are located in Memphis, Nashville, Knoxville, Chattanooga, Johnson City, and Jackson. For contact information please visit**:** http://www.tennessee.gov/humanserv/rehab/cics.pdf

Disability Determination **1-800-342-1117**

The Tennessee Disability Determination Services (DDS) is a section within the Division of Rehabilitation Services of the Department of Human Services. The DDS operates by agreement between the State of Tennessee and the Social Security Administration to process Social Security and Supplemental Security Income disability claims. For more information regarding Social Security Disability go to the following link: http://www.tennessee.gov/humanserv/rehab/dds.html

Services for the Blind and Visually Impaired **1-800-628-7818**

Tennessee Services for the Blind and Visually Impaired provides specialized services to persons who have dual sensory impairments. A Deaf-Blind Specialist in the Central Office provides technical assistance to field staff on how to best serve this population. The Specialist is also involved in advocacy activities on behalf of persons who are deaf-blind and plays an important role in educating the public about the specialized needs and abilities of persons who are deaf-blind.

Rehabilitation Teaching Program

The Rehabilitation Teaching Program is designed to provide services to individuals of all ages who are blind or visually impaired to better enable them to live independently in their homes and communities. Professionally trained

Rehabilitation Teachers across the State provide a wide range of independent living services to working age adults, older individuals and family members who are visually impaired. Teachers work with the client both on a one-on-one basis in the individual's home and in group settings. The teachers are also active in establishing and nurturing support groups in the community. All services are customized to meet the individual's needs and may include:

- Guidance and Counseling
- Family Counseling
- Orientation and Mobility Services
- Instruction in Communication Skills such as Braille, use of tape recorders, talking books, etc.
- Home Management Training
- Personal Adjustment Services
- Instruction in Recreational Activities; and,
- Information and Referral

The Older Blind Project is administered by the Agency's Rehabilitation Teachers who direct the efforts of nine teacher assistants. These assistants work exclusively with individuals who are at least 55 years old and have a visual impairment and provide direct services to individuals on a one-on-one basis and coordinate services which may be available from other agencies and organizations. They also work closely with the Area Offices on Aging and senior citizen centers across the state to assist persons who are visually impaired to access services available through those agencies. All services are provided under the supervision of a Rehabilitation Teacher.

Tennessee Technology Access Program (TTAP)

The Tennessee Technology Access Program (TTAP) is a statewide program designed to increase access to, and acquisition of, assistive technology devices and services. Through it’s four core programs: Funding Assistance, Device Demonstration, Device Loan, and Device Reutilization, TTAP and a network of five assistive technology centers help people with disabilities and their families find and get the tools that the clients need to live independent, productive lives where and how they choose.

Each of TTAP’s core programs is uniquely designed to both maximize limited resources and improve the understanding of, and to gain better access to, assistive technology devices and services.

TTAP provides funding to five regional assistive technology centers across Tennessee. The centers provide training, evaluation, minority outreach and advocacy services. The staff at each of the centers works closely with businesses, school systems, vocational rehabilitation and the medical community to increase the independence and productivity of persons with disabilities through

the use of assistive technology devices and services.
http://www.tennessee.gov/humanserv/rehab/ttap.html

Tennessee Department of Health (TDOH)

TDOH Cooperation with TDHS

T.C.A. § 71-6-113 states that when the Department of Human Services is unable to find a resource for any person in need of protective services who, because of physical illness, is in need of specialized care or medical treatment, the Department of Health, shall, based upon available resources, give priority to such person for appropriate placement or treatment if such person is eligible for placement.

Patient Care Advocate

A Patient Care Advocate is located in the Tennessee Department of Health in Nashville. The Patient Care Advocate may work with staff in Adult Protective Services primarily in five (5) areas including:

- Abuse / neglect cases in long-term care facilities when the Health Care Facilities staff is involved and the patient requests the assistance of the advocate;
- adults requiring long term care are inappropriately placed;
- problems and concerns with Pre-Admission Evaluations (PAEs);
- Medicaid discrimination matters; and
- financial problems of adults in long-term care facilities.

The abuse / neglect referrals within long-term care facilities will continue to be made to the Health Care Facilities staff by APS staff when investigating a referral. They will in some instances request the involvement of the Patient Care Advocate in the provision of protective services in these abuse / neglect case situations. When there is a long-term care situation not involving abuse / neglect, in which the assistance of the Patient Care Advocate is needed, the referral should be made to the Director of Patient Care Advocacy.

Healthcare Facilities

The Department of Health is responsible for licensing healthcare facilities such as nursing homes, assisted living, Home for the Aged, and hospitals. They also license home health agencies, hospice, and home medical equipment providers. DoH certifies Intermediate Care Facilities (ICF) for the intellectually disabled

population. DoH accepts referrals of abuse / neglect / exploitation of patients residing in a licensed or certified facility. **Click on the appropriate facility listed below for the standards or rules, especially for decision making:**

- Hospitals-- http://www.tennessee.gov/sos/rules/1200/1200-08/1200-08-01.pdf
- Nursing Homes- http://www.tennessee.gov/sos/rules/1200/1200-08/1200-08-06.pdf
- Homes for the Aged-- http://www.tennessee.gov/sos/rules/1200/1200-08/1200-08-11.pdf
- Assisted Living Facilities-- http://state.tn.us/sos/rules/1200/1200-08/1200-08-25.20091223.pdf
- Home Health Agencies-- http://www.tennessee.gov/sos/rules/1200/1200-08/1200-08-26.pdf

Vulnerable Person's Registry

The Department of Health is responsible for maintaining the Vulnerable Person's Registry. This registry includes the names of individuals who have been determined after due process to be the perpetrators of abuse, neglect or exploitation of a vulnerable adult or abuse or neglect of a child. For more information on the Vulnerable Person's Registry, click here: https://health.state.tn.us/AbuseRegistry/default.aspx

Refer to Investigations Policy and Practice Guide for requirements for checking the Vulnerable Person's Registry.

Health Related Boards – Complaint Hotline: 1-800-852-2187

The Division of Health Related Boards, also within the Department of Health, provides administrative support to the twenty-six (26) boards, committees, councils and one (1) registry that are charged with the licensure and regulation of their respective health care professionals, as well as the Office of Consumer Right to Know.

The mission of each board is to safeguard the health, safety, and welfare of Tennesseans by requiring those who practice health care professions within this State to be qualified. Examples of licensing / regulating boards include, but are not limited to: nurses, nurse's aide, doctor, physical therapists, etc. The boards interpret the laws, rules, and regulations to determine the appropriate standards of practice in an effort to ensure the highest degree of professional conduct. The boards are also responsible for the investigation of alleged violations of the Practice Act and rules and are responsible for the discipline of licensees who are found guilty of such violations.

Board members, with few exceptions, are appointed by the Governor. Tennessee statute mandates that specific health care professionals submit information to the Department, regarding details of their training, specialty certification, and practice.

Click here http://health.state.tn.us/boards/boards.htm for information on specific board, committees, and councils.

Tennessee Department of Mental Health

Guide to search for mental health providers:
http://state.tn.us/mental/MentHealtSerProviders.html

Cooperation with DHS -- T C.A. 71-6-113

T.C.A. 71-6-113 states that when the Department of Human Services is unable to find a resource for any person in need of protective services who, because of mental or developmental disabilities, is in need of specialized care or medical treatment, the Tennessee Department of Mental Health (TDMH) and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) shall, based upon available resources, give priority to such person for appropriate placement or treatment if such person is eligible for placement.

TDMH is required to report incidents of abuse, neglect or exploitation to DHS and give information relevant to the reported incidents when those incidents occur in mental health care facilities that are not operated directly by TDMH.

When necessary to complete an investigation, APS has access to TDMH records, except for records of alcohol and drug treatment which require a release of information signed by the patient or a court order granting access.

TDMH is required, within available resources, to give priority for an appropriate placement to a person in need of specialized care or treatment due to mental illness or mental retardation who is also in need of protective services. This does not mean that they will accept any protective service client APS refers to them for placement in an institution. However, if the client is in need of protective services and needs treatment at a TDMH facility, TDMH is required to accept the APS client for appropriate placement before they accept other individuals who may also be waiting for admittance. See T.C.A. 71-6-113(b).

There may be times when APS is unable to obtain the needed services from TDMH or Tennessee Department of Intellectual and Developmental Disabilities (DIDD). A process has been established and is to be used to notify DHS-APS State Office when:

- Any action or inaction on the part of a facility or staff of the TDMH or DIDD puts an APS client at continued or greater risk of harm.

In the event of any such situation which cannot be resolved at the local level in a timely manner to ensure the safety and protection of the APS client, the supervisor will be notified of the situation and will attempt to resolve the issues by working with representatives from the local offices of the other agencies.

APS Program Supervisors should attempt to resolve issues by working with agency representatives at the regional level.

If mental health services issues are unresolved and a client is at risk, notify APS State Office using the form "*Adult Protective Services Request for Assistance from the Tennessee Department of Mental Health*."

If issues remain unresolved with the Tennessee Department of Intellectual and Developmental Disabilities, notify State Office with the form "*Adult Protective Services Request for Assistance from the Department of Intellectual and Developmental Disabilities.*"

The electronic forms are to be used because of the capability of the expandable fields to capture all the information about the client's situation. A handwritten copy should be pre-printed for use when access to the computer is unavailable and the situation needs to be addressed immediately.

When completed, the electronic or handwritten form should be e-mailed or faxed to State Office. APS State Office will then take steps to intercede and request the assistance of TDMH or DIDD staff at the state level to resolve the situation.

This notification process also applies when any TDMH staff refuses to provide access to their records during an investigation, excluding alcohol and drug treatment records which are protected by federal statute. The request for assistance form is used to document the situation.

This notification process to TDMH and/or DIDD will not delay any APS investigation or other efforts to reduce risk to the APS client, but will serve as a uniform way to respond when APS has been unable to access specific needed services from these agencies for APS clients.

TDMH may be available to provide services to clients who have mental health issues. Some of the services are provided directly by TDMH and some are contracted. Some of the services include:

Use of Mental Health Crisis Teams

NEW NUMBER – Toll-free Adult Statewide Crisis Telephone Line
1-855-CRISIS1 (274-7471)

This line operates 24 hours a day, 7 days a week and is open to anyone who needs mental health crisis services. The call is routed to the closest crisis team. If all teams are busy, the line rolls to a backup line that can either handle the call or contact crisis workers in the caller's area for direct intervention. Someone is always available to answer and locate crisis services.

- Link to Mental Health Involuntary Commitment Forms - http://tn.gov/mental/legalCounsel/ModelForms.html

FAQ's about Mental Health Crisis Teams

Where are TDMH Crisis Teams available?

Crisis Teams are available to all of Tennessee's ninety-five counties.

What is the appropriate role of the Crisis Team?

The Crisis Team should be called in a psychiatric emergency to make the decision as to whether hospitalization or in-patient stabilization is necessary. Referral to the Crisis Team should be made when a mental illness crisis is suspected and should be based on the behaviors an individual is currently exhibiting, *i.e.*, homicidal, suicidal, hostile, aggressive, threatening, responding to stimuli others can't hear or see, or disorientation (due to mental illness) to the extent of endangerment to themselves or others.

What information does the Crisis Team need when asking to provide help?

The Crisis Team is being asked to assess the individual for treatment. They need to be given the details of why a mental illness crisis is suspected. Describe the behaviors the individual is currently exhibiting. If known a brief behavioral and family mental illness history should be shared with the team, *i.e.*, history of mental illness behaviors, treatment, medications, alcohol and drug abuse, etc.

How will the Crisis Team respond?

There is no statewide uniform response procedure. When calling to make a referral, ask for the team's procedures to assess for treatment. The Crisis Team may come to the client or they may request that the individual needing assessment come or be brought to them. There may be some situations when the client's condition or, the interests of an accurate assessment, necessitates that the client be assessed in his/her own environment.

If the Crisis Team declines to assess the individual for treatment, what recourse can be employed?

The functions of a Crisis Team are specifically defined by TDMH. To insure that appropriate referrals are made, it is advisable for field staff and the local Crisis Team to discuss referral scenarios (with case examples) before a crisis referral needs to be made. Any concern about the response of a Crisis Team should be brought to the attention of the executive director of the local mental health center.

If the issues cannot be resolved at the local level, and the individual and/or others remain in danger, request assistance from State Office staff in the following situations:

- If the Crisis Team refuses to assess the APS client in his/her own environment when this is needed to determine the extent of risk or to determine capacity;
- If the Crisis Team refuses to mark "(C)" unable to avoid serious impairment or injury from specific risks" on the emergency request form as a criteria for involuntary treatment;
- If any TDMH staff refuses to provide access to records during an investigation, excluding alcohol and drug treatment records as noted in T.C.A. 71-6-103(j) and 113.
- If there is need to document APS requests for assistance with the client who has dual diagnosis of mental illness **and** mental retardation, and the crisis team is not responding appropriately.

Use the form "*Adult Protective Services Request for Assistance from the Tennessee Department of Mental Health."*

If you feel there is imminent danger to the individual, yourself or others do not wait; call the police!

Mental Health Counseling

Individual and group counseling is available at local community mental health centers. TDMH contracts with the local community mental health centers to provide mental health counseling for all ages. In addition, a community may have private practice therapists who provide mental health counseling.

Housing Services for Persons with a Mental Illness

TDMH licenses mental health group homes, now called Mental Health Supportive Living. Some group homes accept clients for the amount of their income, usually SSI and/or SSA.

Click on the link below to search by county for all TDMH licensed facilities: https://mhddapps.state.tn.us/Licensure/Inquiry.aspx?RPT=TDMHDD%20License%20Inquiry

"Housing within Reach" offers permanent housing solutions for Tennesseans diagnosed with a mental illness or a co-occurring disorder. For more information visit their website: http://www.housingwithinreach.org/

Supportive Living Housing Program

Service Description

TN Code Annotated §12-4-330 directs the Tennessee Department of Mental Health to reimburse certain supportive living facilities in Tennessee counties. The Fiscal Services Section administers this program. The rate of reimbursement is $2.00 a day x 30% of eligible residents.

This service provides a supplement to eligible facilities in certain counties in Tennessee. After a facility is certified by the Fiscal Services Section to be eligible for the program, facilities submit reimbursement forms to the Section each month. The Section reimburses these claims until the funds for the program run out. Participating counties are:

- Davidson
- Dyer
- Hamilton
- Hardeman
- Knox
- Lincoln
- Madison
- Obion
- Shelby
- Warren
- Wilson

For more information on the supportive living housing program, click on the following links:

- Service Description
  http://state.tn.us/mental/recovery/housing6.html#desc
- Why do we fund it?
  http://state.tn.us/mental/recovery/housing6.html#why
- Whom does it serve?
  http://state.tn.us/mental/recovery/housing6.html#whom

- What are the outcomes?
  http://state.tn.us/mental/recovery/housing6.html#outcomes
- What evidence is available to support the service?
  http://state.tn.us/mental/recovery/housing6.html#evidence

Assisted Living Permanent Supportive Housing Program Service Description

The Assisted Living Program is a housing program that bridges the gap in the housing continuum between supportive living facilities (the more restrictive group homes) and congregate/individual rental or home ownership. The program not only provides housing to consumers but also employs consumer staff members, who offer structure, support, and supervision as needed to residents. Additionally, staff members support residents as they develop independent living skills and gain confidence in their ability to move toward more independence.

For more information on the assisted living permanent supportive housing program, click on the following links:

- Service Description
  http://state.tn.us/mental/recovery/housing5.html#desc
- Why do we fund it?
  http://state.tn.us/mental/recovery/housing5.html#why
- Whom does it serve?
  http://state.tn.us/mental/recovery/housing5.html#whom
- What are the outcomes?
  http://state.tn.us/mental/recovery/housing5.html#outcomes
- What evidence is available to support the service?
  http://state.tn.us/mental/recovery/housing5.html#evidence

Independent Living Assistance Service Description

The Independent Living Assistance program provides specific, temporary financial support to consumers to allow them to live independently in the community by providing funding for rental deposits, rental assistance, utility deposits, utility payments, eye care, and dental care.

Funding is provided to agencies that provide assistance to consumers by directly paying landlords, utility companies, and doctors for rent, utilities, eye care, and dental care.

For more information on the independent living assistance program, click on the following links:

- Service Description
  http://state.tn.us/mental/recovery/housing8.html#desc

- Why do we fund it?
  http://state.tn.us/mental/recovery/housing8.html#why
- Whom does it serve?
  http://state.tn.us/mental/recovery/housing8.html#whom
- What are the outcomes?
  http://state.tn.us/mental/recovery/housing8.html#outcomes
- What evidence is available to support the service?
  http://state.tn.us/mental/recovery/housing8.html#evidence

MENTAL HEALTH AGENCIES AND CONTACTS THAT COORDINATE HOUSING: *(This listing was updated June 24, 2009)*

- **Helen-Ross McNabb**, Jana Morgan, Knoxville, TN 865-544-3841, x. 4108
- **Peninsula**, Marilyn Wooliver, Knoxville, TN 865-670-1059 or 1-865-525-7500
- **Ridgeview Psychiatric Hospital** & Center, Sharon Stratton, Oak Ridge, TN 865-482-1076
- **Mental Health Cooperative**, Carolyn Crawford-Fitzgerald, Nashville, TN 615-743-1462
- **Centerstone Community Mental Health Centers**, Gerald McCann, Hohenwald, TN 931-796-5916
- **Centerstone Community Mental Health Centers**, Suzie Premo, Clarksville, TN 931-920-7235
- **LifeCare Family Services**, Tabbatha Colburn, Nashville, TN 615-781-0013 x. 5195
- **Carey Counseling Center, Inc.,** Fran Howe, McKenzie, TN 731-352-3050
- **Frontier Health**, David Bowers, Bristol, TN 423-989-4545
- **Professional Care Services of West Tennessee, Inc.**, Paul Shaver, Covington TN 901-475-3580
- **Quinco Mental Health Center**, Michelle Burrell, Bolivar, TN 731-658-6113
- **AIM Center**, Elizabeth Hendrix, Chattanooga, TN 423-624-6591
- **Cherokee Health Systems**, Lisa Mayes, Morristown, TN, Tazewell, TN 423-626-8271
- **Grace House of Memphis**, Charlotte Hoppers or Cynthia Poole, Memphis, TN 901-276-2364
- **Southeast Mental Health Center**, Tekela Cooper, Memphis, TN 901-452-6941
- **Comprehensive Counseling Network**, or **Frazier Family Counseling**, Steve Douglas, Memphis, TN 901-353-5440
- **Generations Mental Health Center**, Brandi Lawson/Jamie Lyle, McMinnville, TN 931-815-1212 x. 240 (Brandi) or x. 248 (Jamie)
- **Volunteer Behavioral Health**, Dennis Phillips, 1-888-756-2740 x. 1557
- **Pathways Behavioral Health**, Pam Newble (case manager) Jackson, TN, 731-541-4549

Speaker's Bureau

The TDMH Office of Public Information operates the Department's Speakers Bureau. Speakers are available, without charge, for civic clubs, special events or an academic setting in Tennessee.

Topics

- General information about the Tennessee Department of Mental Health and Department of Intellectual and Developmental Disabilities
- Drop In Centers
- Criminal Justice/Mental Health Liaison
- Respite Services
- Regional Mental Health Institutes
- Forensics
- TN Emergency Management
- Cultural diversity mental health issues
- Assistive technology research / ethical issues
- Clinical psychology
- Quality management
- Behavior management
- Developmental disabilities
- Tennessee Alliance for the Mentally Ill

- Legal issues in mental health and mental retardation
- Mental retardation / developmental disability issues
- Administrative procedures
- Child and adolescent issues
- Selected mental illnesses
- Adult Services
- Nashville Connection
- Nursing
- Co-Occurring Disorders (MH/A&D)
- Legal issues
- Clinical Psychology
- Suicide

How to Request a Speaker

Requesting agencies/organizations should provide the following information and provide a minimum of two weeks lead time for making arrangements.

- Date and time speaker needed
- Location
- City or town
- Topic desired
- Desired length of presentation
- Contact name, address and phone number

To request a speaker, call 615-532-6597.

Criminal Justice Liaison

The Criminal Justice & Mental Health Interface Office provides the interface between criminal justice and mental health services by:

- Facilitating the process of developing and maintaining relationships between the criminal justice and mental health services systems to achieve common goals;

- Promoting policies that will decriminalize mental illness;

- Seeking resources for establishing services to divert persons with mental illness from the criminal justice system to the mental health service system;

- Providing technical assistance to communities on identifying and developing systems that promote diverting persons with mental illness from the criminal justice system to the mental health services system;

- Participating in state and local activities to address the needs of persons with mental illness who are involved in the criminal justice system;

- Coordinating and facilitating the activities of the statewide Criminal Justice/ Mental Health Advisory Board, and

- Developing and maintaining training curriculum for personnel in the criminal justice and mental health systems.

For more information on the Criminal Justice & Mental Health Interface Office, click here: http://state.tn.us/mental/policy/cjinterface.html

Case Management

Mental health case managers serve as the agent for linking, facilitating, and monitoring the receipt of direct services and supports. An assessment process provides for measurements of intensity and duration needed and proposed objectives to be met in the service plan. Mental Health Case Management is a benefit of the TennCare Partners Program. Contact your local community mental health center for more information.

TDMH Ombudsman

An "Ombudsman" is person whose job is to work out problems that an individual may have with the government. The Office of Consumer Affairs Ombudsman program offers direct assistance to individuals who are experiencing problems accessing services and supports.

What can an Ombudsman do?

The Ombudsman is available to help service recipients and their families resolve questions or problems. The Ombudsman helps to resolve problems by mediating the concerns of each person involved in the situation. The Ombudsman may serve as an advocate for the service recipients, the family, the State or the provider when appropriate but is always working for the service recipients. The Ombudsman accepts calls from all over the State.

For the Service Recipient:

- The Ombudsman takes time to listen to the concerns;
- The Ombudsman will keep these matters confidential;
- The Ombudsman will provide assistance to help resolve the problems;
- The Ombudsman can also explain the rights and responsibilities of a resident.

For Families and Friends:

- An Ombudsman can help clarify regulations that apply to the situation;
- Provide information regarding alternatives;
- Provide Information regarding access to services and supports;
- Make helpful referrals to other agencies.

When should the Ombudsman be contacted?

When service recipients or their families cannot resolve their problems through consultation with the facility staff or governmental agencies involved, they should contact the Office of Consumer Affairs Ombudsman.

How do I contact the Ombudsman?

1-800-560-5767 from 8 AM to 4:30 PM, Monday through Friday, or
email: oca.mhdd@state.tn.us

Office of Consumer Affairs - TDMH

The Office of Consumer Affairs (OCA) is operated by the TDMH to assist consumers in addressing issues and finding their way through the system. Staff can also help consumers exercise their appeal rights if the problem cannot be resolved otherwise. The OCA plays a crucial role for service recipients and consumers by:

- Promoting the interests of service recipients;
- Providing direct assistance to recipients through its Ombudsman program, and
- Providing the tools for consumers to advocate for themselves through training opportunities and the promotion of self-help programs.

For information regarding the above responsibilities, Call 1-800-560-5767 from 8 AM to 4:30 PM, Monday through Friday, (also 615-532-6700 local Nashville, Fax 615-253-3920)

For contact information for the Office of Consumer Affairs: oca.mhdd@tn.gov

OCA also has a form available for pre-planning of mental health treatment decisions. Below are links to the form and to documents to assist with its use.

NOTE: The presence of a signed and witnessed declaration for mental health treatment does not prevent the provision of APS services. If there are questions about the legality of actions to be taken if the individual has signed this form, contact the supervisor and/or State Office who will confer with Legal.

Declaration for Mental Health Treatment and Brochure

Q & A about completing a Declaration for Mental Health Treatment (PDF*)
http://tennessee.gov/mental/t33/DMHT_bro.pdf

The Declaration for Mental Health Treatment form (PDF*)
http://tennessee.gov/mental/t33/DHMT_FORM.pdf

Guide for Providers on Declaration for Mental Health Treatment (PDF*)
http://state.tn.us/mental/t33/MHTDecProviderGuide.pdf

Other Forms and Documents Related to Mental Health and Developmental Disabilities Law (Click the link below.)

More Mental Health Law and Related Documents
http://tennessee.gov/mental/t33/MHTDecProviderGuide.pdf

There is a wide range of material on specific mental health and substance abuse issues available to the public and to mental health, developmental disabilities, and substance abuse professionals. To obtain information and documents, email or call the OCA at the address and numbers given above on this page.

Assistance with Obtaining Medication Related to Mental Illness

Prescription Assistance Programs available to people losing TennCare:

- **RX Outreach** - Provides some free generic medicines for problems like asthma, high blood pressure or depression. Enrollment is automatic for people who are dis-enrolled from TennCare.
    - RX Outreach can provide these medicines by mail order.
    - RX Outreach generics are also available from *some local pharmacies*. People can find out which local pharmacies are participating by calling the toll-free number 1-888-486-9355 or visiting the TN HEALTH OPTIONS web site. www.tnhealthoptions.org.
- **Express Access Discount Card** - Provides savings up to 10 percent on brand-name prescription medicines and up to 50 percent on generic

- medicines purchased at participating pharmacies. Enrollment in Express Access is automatic for people being disenrolled from TennCare.

- **Additional Prescription Assistance** - People coming off TennCare have or will receive information on how they can get FREE brand name drugs for each of their medications, directly from the drug makers. There is nothing former enrollees need to do to receive this service; however, if they have not received information about this assistance, they can get information on their own by calling 1-800-772-7986 or visiting www.pparxtn.org on the web.

Peer Support Center for Persons with Mental Illness (Formerly Called Drop-in Centers)

A peer support center is a central place for consumer self-help, advocacy, education and socialization. Through the peer support center, consumers with mental illness and co-occurring disorders develop their own program to supplement existing mental health services and expand the resources of the community. A peer support center provides a socialization service that addresses the isolation felt by many consumers with mental illness. It is open to all consumers with mental illness. No admission fee or membership fee is charged. Peer support centers are usually open on nights, weekends and holidays when professional mental health programs are customarily closed. Consumers can come together at a peer support center to make friends and socialize.

Click here to view listing of Peer Support Centers.
http://tennessee.gov/mental/recovery/PSCenters.html

Support/Education/Transportation/Homelessness (Seth) Campaign

Building on the success of the community collaboration model of the Creating Homes Initiative (CHI), the SETH Campaign was announced and implemented in 2004. The SETH Campaign is a targeted, grassroots, local-community, multi-agency collaboration to increase recovery service options and availability for Tennesseans diagnosed with mental illness and co-occurring disorders in the areas of:

- Support
- Employment / education
- Transportation
- Housing / homelessness

These four key components are essential for persons with mental illness and co-occurring disorders to fully integrate into and become contributing members of their communities of choice.

Housing was the first major area of concentration for the SETH Campaign followed by Employment / Education. Subsequently, SETH will focus on Support and Transportation Services.

Click on this link for a list of regional SETH facilitors:
http://state.tn.us/mental/recovery/reg_fac_map.html

Projects for Assisting in the Transition from Homelessness (PATH) Program

Service Description

Projects for Assistance in Transition from Homelessness are a federal grant program to assist people who are homeless and who are diagnosed with mental illness and co-occurring disorders. PATH funds community-based outreach, mental health, substance abuse, case management and other support services, as well as limited housing services. The program is administered through contracts with Community Mental Health Agencies (CMHA) and other community agencies that reach out and transition homeless persons with mental illness to ongoing recovery services. Mental health professionals are responsible for developing the program and providing the services in the community. Case management is the foundation of the service delivery system. PATH funding supports programs in Knoxville, Nashville, Chattanooga, Memphis, Jackson, Clarksville, Murfreesboro and Johnson City.

To find out more about the PATH program in your area and contact information,
http://tennessee.gov/mental/recovery/PATHcontacts.pdf

Health Options Available to Former TennCare Enrollees

For information on the Tennessee Behavorial Health Safety Net
http://www.tennessee.gov/mental/safetynet.html

To find out what options are available to people coming off TennCare

Call 1-888-486-9355 or on the web go to www.tnhealthoptions.org

Other Tennessee Health Options Services:

- Ask-A-Nurse - Call 1-888-486-9355 to talk with a registered nurse about a health or medical condition.

- Find ***healthcare resources by county***, including local health departments and nonprofit clinics that may provide low-cost or free services based on

- the ability to pay. Call toll-free 1-888-486-9355 or visit the web site. www.tnhealthoptions.org

- Insulin - The State will offer a transitional assistance program for insulin-dependent TennCare enrollees who are losing coverage. The program will provide four (4) months of insulin and supplies for eligible individuals disenrolled from the program as part of the State's Health Care Safety Net services. Call the Health Options hotline at 1-888-486-9355 for more information.

- Services for people with severe mental illness who are coming off TennCare, including prescription drugs and services provided through community mental health agencies.

Office of Managed Care – TDMH

TennCare Partners Eligibility:

To be eligible for services under the TennCare Partners Program, a person must meet one of the following:

1. Eligible for full TennCare or Medicaid – Be eligible for TennCare or Medicaid as determined by the Department of Human Services. More information is available on the TennCare web site: www.state.tn.us/tenncare/members.html

OR

2. Eligible for Mental Health Benefits Only (State-Only) – If not currently eligible for TennCare AND meets the following:
   - Been determined ineligible for TennCare or have a pending TennCare application; and
   - Not be a prior TennCare enrollee terminated from coverage as a part of TennCare reform with access to safety net services; and
   - Not have access to private health insurance; and
   - Not have Medicare coverage or getting VA benefits; and
   - Be a U.S. citizen or a legal resident alien; and
   - Be a resident of Tennessee; and
   - Have been identified as SPMI/SED (CRG = 1, 2, or 3; TPG = 2); and
   - Have family income no greater than 100% of the Federal Poverty Level (FPL); and

- Must not be an inmate.

To qualify for this category a person should go to their local CMHA which can assist them. To locate a local CMHA, click on the following: http://state.tn.us/mental/MentHealtSerProviders.html

3. Eligible for mental health benefits for involuntary commitments, evaluations and services at a regional mental health institute or an approved psychiatric facility (judicial) – If not currently eligible for TennCare and meets the following:
    - Have been involuntarily committed for evaluation and treatment, as documented by either two Certificates of Need or a court order

For additional information, please contact:

TDMH Office of Consumer Affairs

1-800-560-5767 from 8 AM to 4:30 PM, Monday through Friday or email: oca.mhdd@state.tn.us

Department of Intellectual and Developmental Disabilities (DIDD)

This Department provides services for people with mental retardation. The onset of the MR must be diagnosed prior to the age of 18 years of age with an IQ of 70 and below. For information about decision making for people with mental retardation, click here: http://www.tennessee.gov/sos/rules/0940/0940-04/0940-04-04.pdf .

DIDD offers several different types of programs for persons with mental retardation. The types of programs are:

- Consumer-directed supports
- Case Management
- Home and Community Based Services
- Family Support

Consumer-directed Supports are state-funded services that are available to limited numbers of eligible people on the DIDD waiting list for services. This program can provide funds up to $2,280 per person per year. These funds may be used for respite, transportation or other services.

Case Management Services provide support for individuals who are supported in the Self-Determination Waiver or on the waiting list for services. Case managers provide information about DIDD programs and services, provide assistance with

completing eligibility application forms, gather information to assess service needs, connect people to generic community services, provide ongoing contact and assistance as needed/requested and will refer people to advocacy organizations and support groups as needed / requested.

Additionally, for individuals enrolled in the Self-Determination Waiver, Case Management Services include ongoing assessment, development, evaluation and revision of the plan of care, assistance with the selection of service providers, provision of general education about the waiver program, including individual rights and responsibilities, and monitoring implementation of the plan of care and initiating individualized corrective actions as necessary (e.g. reporting, referring or appealing to appropriate entities.)

Case managers:

- Assist the individual and family with services planning
- Assist the individual in accessing needed services
- Monitor the delivery of services to ensure they meet the needs and expectations of the person
- Assist the person in resolving issues of concern including filing appeals, accessing complaint resolution processes, etc
- Maintain regular contact with the individual and/or family and involved service providers

DIDD Medicaid Waiver Home and Community Based Services

Medicaid Home and Community-based Services Waiver programs were developed as an alternative to services provided in an institutional setting and are the primary source of supports and services for people with mental retardation who live in the community. Examples of services which persons may be eligible to receive through the Home and Community-Based Services Waiver include:

- Support Coordination
- Residential Services (Residential Habilitation, Supported Living, Family Model Residential Support)
- Day Services
- Behavior Services
- Physical, Occupational and Speech Therapy Services
- Nursing and Nutrition Services
- Respite Services and Behavioral Respite Services
- Personal Assistance

- Transportation

Click on the link below for more information on the DIDD waiver program:
http://www.tennessee.gov/dids/consumer_services/fgmwb.pdf

DIDD Tennessee Self Determination Waiver Program

The Self-Determination Waiver program offers services to persons with mental retardation who have moderate service needs that can be satisfactorily met with a cost-effective array of home and community services that complement other supports available to them in their homes and community. In addition to Case Management services provided by DIDD, persons may be eligible to receive the following services through the Tennessee Self-Determination Waiver program:

- Day Services
- Behavior Services
- Physical, Occupational and Speech Therapy Services
- Respite and Behavioral Respite Services
- Personal Assistance
- Transportation

The DIDD Waiting List

Individuals who are eligible for services will be assessed and assigned a Category of Need. These needs are: Crisis, Urgent, Active and Deferred.

Crisis
There are 4 categories that define a crisis need.

The person needs services immediately for one of the following reasons:

1. Homeless

- The individual is currently homeless
- The individual will be homeless within 90 days

2. Death, incapacitation, or loss of the primary caretaker and lack of an alternate primary caretaker

- The primary caretaker died
- The primary caretaker became mentally or physically incapacitated (permanently or expected to last more than 30 days)

- The primary caretaker serves as the primary caretaker for one or more other individuals with serious mental, physical, or developmental disabilities and is unable to provide an acceptable level of care for the enrollee

- The primary caretaker must be employed to provide the sole or primary income for the support of the family

3. Serious and imminent danger of harm to self or to others by the individual.

- The individual's current pattern of behavior poses a serious and imminent danger of self-harm which cannot be reasonably and adequately managed by the caretaker

- The individual's current pattern of behavior poses a serious and imminent danger of harm to others which cannot be reasonably and adequately managed by the primary caretaker

4. The person has multiple urgent issues that are likely to result in a crisis situation if not addressed immediately and the person meets two or more of the following criteria:

- Aging or failing health of caretaker and no alternate available to provide supports

- Living situation presents a significant risk of abuse or neglect

- Increasing behavioral risk to self or others

- Stability of the current living situation is severely threatened due to extensive support needs or family catastrophe

- Imminent discharge from other service system (e.g. Department of Children's Services, mental health institute, state forensics unit)

Urgent

The person meets one or more of the following criteria:

- Aging, or failing health of the caretaker and no alternate available to provide supports

- Living situation presents a significant risk of abuse or neglect

- Increasing behavioral risk to self or others

- Stability of the current living situation is severely threatened due to extensive support needs or family catastrophe

- Imminent discharge from other service system (e.g. Department of Children's Services, mental health institute, state forensics unit)

Active and Deferred

The person or the person's family or guardian / conservator is requesting access to services but the person does not have intensive needs which meet the urgent or crisis criteria above.

Enrollment in the Self Determination Waiver program will be prioritized and offered first to persons in the Crisis category, then to individuals in the Urgent category, and then to persons in the Active and Deferred category up to the number of persons approved to be served in the program each year.

Requests to reevaluate the Category of Need should be directed to the Regional Office. The decision of the Regional Office can be appealed to the DIDD Central Office staff by submitting written information to:

Director of Intake – Phone 615-741-6148 - Fax 615-532-9940

Family Support Program

In 1992, at the urging of disability advocates and families, the Tennessee Legislature established the Family Support Program. The program is funded by state dollars and designed to assist individuals with severe disabilities and their families to remain together in their homes and communities. Family Support is not a substitute for more comprehensive services provided under other programs, including the Medicaid HCBS Waiver, TennCare, Medicare, or private insurance.

The primary purpose of the program is to support

- Families who have school-aged or younger children with severe disabilities

- Adults with severe disabilities who choose to live with their families

- Adults with severe disabilities not supported by other residential programs funded by state or federal funds

Services can include but are not limited to: respite care, day care services, home modifications, equipment, supplies, personal assistance, transportation,

4homemaker services, housing costs, health-related needs, nursing and counseling.

Services are flexible and responsive to families and their needs. An essential element of the Family Support Program is family and consumer involvement. Local and district councils have been established and meet on a regular basis to oversee and provide advice on the distribution of local services. For more information click on the following links:

- Council - http://www.tennessee.gov/dmrs/family_support/council.html
- Coordinators - http://www.tennessee.gov/dmrs/family_support/coordinators.html
- Agencies - http://www.tennessee.gov/dmrs/family_support/agencies.html
- Support Guidelines (PDF) - http://www.tn.gov/didd/family_support/GUIDELINES20102011.pdf
- Frequently Asked Questions - http://www.tennessee.gov/dmrs/family_support/faq.html

DIDD Office of Consumer Affairs Contacts

Director of Consumer Services 615-741-6674 (Phone), 615-532-9940 (Fax)

Assistant Director of Consumer Services 615-253-4632 (Phone), 615-532-9940 (Fax)

Advocacy Grant Coordinator 615-253-6882 (Phone), 615-532-9940 (Fax)

DIDD Resources - Click on the link for more information on the following:

TDMHDD Licensure Search - https://mhddapps.state.tn.us/Licensure/Inquiry.aspx?RPT=TDMHDD%20License%20Inquiry

DIDD Intake Referral Form (PDF) - http://www.tennessee.gov/dmrs/consumer_services/IntakeReferralForm.pdf

Family Guide to Medicaid Waiver (PDF) - http://www.tennessee.gov/dmrs/consumer_services/fgmwb.pdf

Individualizing Residential Supports Resource Manual (PDF) - http://www.tennessee.gov/dmrs/consumer_services/irsrm.pdf

The Family Handbook (PDF) - http://www.tennessee.gov/dmrs/consumer_services/FamilyHandbook.pdf

Guide to Self-Determination Waiver Program-DIDD
http://www.tn.gov/didd/provider_agencies/resources/SelfDirectionGuide010509FINAL.pdf

HIPAA Privacy Notice (PDF)
http://www.tennessee.gov/dmrs/consumer_services/PrivPractBrocFINAL%20Oct%202007.pdf

Planning and Implementation Resource Manual
http://www.tennessee.gov/dmrs/provider_agencies/planning_resource.html

DIDD Conservatorship Forms

- Conservatorship Information Form (PDF)
  http://www.tennessee.gov/dmrs/consumer_services/Conservatorship/ConsvInfoForm.pdf

- Consent to Serve (PDF)
  http://www.tennessee.gov/dmrs/consumer_services/Conservatorship/ConsentToServe.pdf

- Affidavit of Indigency (PDF)
  http://www.tennessee.gov/dmrs/consumer_services/Conservatorship/AffidavitOfIndigency.pdf

- Physician Report (PDF)
  http://www.tennessee.gov/dmrs/consumer_services/Conservatorship/PhysicianReportConsv.pdf

Community Inclusion Project: Comprehensive Assessment and Treatment for Persons with Dual Diagnosis
http://www.tennessee.gov/dmrs/consumer_services/CIPManual082307.pdf

DIDD Provider Agencies List (PDF)
https://mhddapps.state.tn.us/Licensure/Inquiry.aspx?RPT=TDMHDD%20License%20Inquiry

AND

http://www.tn.gov/didd/provider_agencies/ProviderList/Provider%20DirectoryApril52011.pdf

Federal Programs

Senior Community Services Employment Program (SCSEP)

This program is now administered under the Dept. of Labor & Workforce Development

SCSEP, funded under Title V of the Older Americans Act, serves persons with low incomes who are 55 years old or over and have poor employment prospects. The program has two purposes: to provide useful community services and to foster individual economic self sufficiency through training and job placement in unsubsidized jobs. Services provided include:

- up to 20 hours a week of part-time employment in community service assignments
- job training and related education opportunities
- opportunities for placement into unsubsidized jobs

Community services assignments include the following activities:

- social, health, welfare, and educational services (particularly literacy tutoring)
- personal assistance, including tax counseling and assistance and financial counseling
- library, recreational, and other similar services
- conservation, maintenance, or restoration of natural resources
- community betterment or beautification
- anti-pollution and environmental quality efforts
- weatherization activities
- economic development; and
- such other services essential and necessary to the community as the U.S. Secretary of Labor, by regulations, may prescribe.

Miscellaneous Websites

Alzheimer's Association
http://www.state.tn.us/comaging/alzheimers2.html

Long-Term Care Ombudsman Program (poster)
http://www.tn.gov/comaging/documents/6981%20Ombudsman%20Poster2.pdf

Senior Centers: Click on the link for a list of centers:
http://www.tn.gov/comaging/documents/center.pdf

Nursing Home Compare
http://www.medicare.gov/NHCompare/home.asp

Miscellaneous Resources

Home Health Agency Complaint Hotline 1-800-541-7367

The Department of Health, Division of Health Care Facilities licenses all home health agencies.

Tennessee Alliance for Legal Services (TALS) 1-888-395-9297

A number of agencies in Tennessee provide legal help for low-income persons. The legal aid programs have lawyers who may work with APS older population. While legal aid typically assists individuals who have low income, they will sometimes assist people who are not low-income, but are abused or over age 60.

On TennLegalAid.com, a legal aid program can be located by county.

Information may also be accessed by going directly to the website of the legal aid programs in Tennessee. The following programs receive federal funding through the Legal Services Corporation (LSC) and handle legal issues within their geographic service areas:

- Legal Aid of East Tennessee
  http://www.tennlegalaid.com/Home/PublicWeb/LegalSvcs/
- Legal Aid Society of Middle Tennessee and the Cumberlands:
  www.las.org
- West Tennessee Legal Services: www.wtls.org
- Memphis Area Legal Services: www.malsi.org
- Medicare and Disability:

The following program is federally-funded and handles the legal needs of migrant and seasonal workers statewide:

- Southern Migrant Legal Services: www.trla.org

The following independent programs assist clients in specific regions of Tennessee:

- Community Legal Center (pro bono assistance in Memphis): www.clcmemphis.com

- Southeast Tennessee Legal Services (Chattanooga area): www.selegal.org

The following, independent, legal service programs are also statewide and assist clients based upon their specific needs:

- Tennessee Justice Center: www.tnjustice.org
- Disability Law and Advocacy Center of Tennessee: www.dlactn.org

Tennessee Disability Coalition 1-888-643-7811

The Coalition is an alliance of organizations and individuals in Tennessee that have joined to promote the full and equal participation of men, women and children with disabilities in all aspects of life.

Click here for more information about the Tennessee Disability Coalition: http://tndisability.org/

The Coalition and its member organizations work together to advocate for public policy that ensures self-determination, independence, empowerment, integration and inclusion for people with disabilities. From the ADA to long-term care, from education to health, from housing to employment, from personal assistance to assistive technology, the Coalition focuses on legislative and administrative supports that improve the lives of individuals with disabilities and their families

Disability Law and Advocacy Center of TN 1-800-342-1660

Disability Law & Advocacy Center of Tennessee (DLAC) advocates for the rights of Tennesseans with disabilities to ensure they have an equal opportunity to be productive and respected members of our society. This agency was previously named Tennessee Protection and Advocacy.

For people who qualify, DLAC may be able to assist with problems related to their disability in the following areas:

- Abuse and neglect outside of the home
- Discrimination in housing, transportation, employment
- Access to public and private programs and services

- Access to mental health, rehabilitation and support services
- Access to appropriate education programs and services
- Obtaining and utilizing assistive technology services and devices
- Access to Vocational rehabilitation services that promote employment and independence

Direct services are individualized and may include the following:

- Information and materials
- Referrals to programs and services
- Training and technical assistance
- Investigations of abuse and neglect
- Negotiation and mediation remedies
- Information to develop self advocacy skills
- Individual or systems advocacy
- Individual or class action litigation

There are no fees for advocacy services. However, there may be fees for training, information packets and aspects of legal representation. All people with disability-related concerns are eligible for information and referral services. Due to limited resources, acceptance of direct advocacy and legal cases must be determined by federal guidelines and public-driven priorities that are approved by the Board of Directors.

The toll-free advocacy assistance unit handles all requests for services, and all information referral services. Visit http://www.dlactn.org/ for more information.

Domestic Violence Hotline **1-800-356-6767**

The statewide Domestic Violence Hotline is a 24-hour, 7 days a week referral and counseling hotline for victims of domestic violence. The counselors are available to offer referrals and to listen. The counselors go through an extensive training process so they can meet the needs of domestic violence victims. Click here to download The Statewide Domestic Violence Poster. http://www.pcat.org/DV_poster_english.pdf

Consumer Affairs **1-800-342-8385**

Consumer Affairs works to protect consumers and businesses from unfair business practices. This division can be used to assist APS clients with scams, fraud and other unfair business practices that APS does not investigate.

Click Here to view a brochure
http://www.tennessee.gov/consumer/documents/Brochure-OfficialC.A..pdf

Eldercare Locator **1-800-677-1116**

The Eldercare Locator is a public service of the U.S. Administration on Aging. The Eldercare Locator is the first step to finding resources for older adults in any U.S. community. Just one phone call or website visit provides an instant connection to resources that enable older persons to live independently in their communities. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caretakers. Information resources may be obtained by from the link below or calling an Eldercare Locator information specialist toll-free at 1-800-677-1116 weekdays, 9:00 a.m. to 8:00 p.m. (ET). Spanish-speaking Information Specialists are on duty.

Social Security Hotline **1-800-772-1213**

This number is for information regarding Social Security, Social Security Disability, Supplemental Security Income, and Medicare. Visit http://www.ssa.gov/ for more information about Social Security including reporting fraud, applying for benefits, and requesting a Social Security card.

Veterans Administration **1-800-827-1000**

The Veterans Administration has many programs and services that are available to veterans, including healthcare, homeless assistance, and vocational rehabilitation. Visit http://www.va.gov/about_va/programs.asp for more information.

Medicare Hotline **1-800-489-4633**

The Medicare hotline can be used to get information on eligibility, prescription drug plans, Medicare appeals, Ombudsman, and other issues related to Medicare. Visit http://www.medicare.gov/ for more information about Medicare.

TennCare Information Line **1-800-669-1851**

TennCare Internet Link – http://www.state.tn.us/tenncare/phonenumbers.html

TennCare Partners Advocacy and Information-1-800-758-1638 or 242-7339 (in Nashville)

The State contracts with the Mental Health Association of Middle Tennessee to operate this line, which provides information specific to the TennCare Partners

2Program (behavioral health services). Itprovides general TennCare information and information on premiums and eligibility.

Health Options **1-888-486-9355**

This is for people who have been dis-enrolled from TennCare.

TennCare Consumer Advocacy **1-800-722-7474**

To arrange for TennCare transportation

TennCare Transportation **1-800-209-9142**

Appendix G
LEGAL INTERVENTION PRACTICE GUIDE

Legal Overview

There are several options under the Tennessee Adult Protection Act which enable the Department to complete an investigation of a report of harm to an adult and to pursue court intervention in order to provide protection to clients who are the Department has determined to be in need of protective services.

These options include the following:

- Search warrant.
- Injunctive relief ordering a caretaker or other person to stop abuse, neglect or exploitation, to stop interfering with an investigation or the provision of protective services, or requiring the caretaker to take protective action.
- Orders seeking only to conduct a mental and/or physical examination of the client to determine capacity to consent to protective services and/or to determine the imminence of harm present due to the client's mental and/or physical condition.
- Non-custodial complaint and order granting the Department the authority to consent to the provision of protective services to a client who lacks the capacity to consent to protective services without placing legal custody of the client with the Department.
- Custodial complaint and order granting legal custody to the Department with authority to consent to medical examination, treatment and/or placement in a nursing or other facility or alternative living arrangement.
- Other legal intervention, such as a petition for conservatorship to manage a person's financial matters and/or physical care or to seek commitment of the client under the mental health law due to the imminent risk the client poses to himself or others due to the client's mental illness.

These options must be carefully considered before withdrawing from an investigation or terminating services in any case situation in which a client is thought to be in need of protection but does not consent or withdraws consent for service.

The decision to take legal action is made as a last resort after all considerations have been taken into account and all practical alternatives have been exhausted. There must be a full understanding of the client's condition and availability of resources to meet the client's needs. We must be sure that intervention by all relatives and friends has been explored. If legal action is determined to be

needed and justified, we will ask for legal intervention at the least restrictive level which will protect the client. The more drastic and intrusive the legal action requested, the more severe the client's condition must be to justify greater intrusion on the client's freedom and autonomy.

The Department's only access to the court is through legal staff. All petitions must be prepared by the DHS staff attorney, both for custodial and non-custodial situations, whether or not an emergency. There are no form complaints or orders which can be used in Adult Protective Services by counselors or supervisors. The decision to refer the situation to DHS legal staff for initiation of legal action is to be made jointly by the counselor and the supervisor.

Legal Referral

All documents needed to pursue any legal action referenced above must be prepared by one of the Department's attorneys pursuant to a legal referral.

Legal Referral for Actions Pursuant to the Tennessee Adult Protection Act

All referrals recommending legal action will be made using the Legal Referral in the automated system.

NOTE: It is essential to fill out the legal referral completely with thorough and accurate information and evidence consisting of eyewitness accounts of the client's circumstances and clear opinions of health care providers that contain the factual basis for the provider's opinion concerning the client's physical or mental condition, as well as information concerning the client's available resources. Obtain any missing information if at all possible prior to sending the legal referral. If you have any questions regarding the sufficiency of the evidence to support the requested legal action, you must consult with the staff attorney.

Lack of adequate and/or accurate information will delay legal intervention due to insufficient evidence, will impact the attorney's ability to take the case to court, and can jeopardize a successful outcome in court leaving the client at risk.

Standard of Proof

"Substantial and material evidence" – The standard for indicating an allegation of abuse, neglect or exploitation and maintaining an open case in order to provide protective services. Substantial and material evidence is relevant evidence that furnishes a reasonably sound factual basis for the decision. This means that there is enough credible evidence regarding whether an event has occurred or a factual situation exists that the decision makes sense when looked at objectively and it is reasonable to act upon that evidence. It is a lesser level, or standard, of evidence than the "preponderance of evidence" or "beyond a reasonable doubt" standards of evidence discussed below and should not be the

basis for deciding to initiate legal action or to indicate a perpetrator or abuse, neglect or exploitation for placement on the Vulnerable Persons Registry.

"Preponderance of the evidence" – The standard for legal intervention to provide protective services without the consent of the client under the Adult Protection Act or to classify a person as a perpetrator of abuse, neglect or exploitation and place the person on the vulnerable persons registry or to affect the person's employment status or to seek injunctive relief.

This standard can be viewed as having to prove a case by evidence that the Department's allegations adds up to the "greater weight of the evidence," or, in other words, that the evidence tips the scales, even slightly, in favor of the legal result sought by the Department. To quantify this standard, it is sometimes said that that the Petitioner has sufficient evidence to show that the allegations are 50.1% in favor of its position. When investigating a case, or in assessing whether to request legal intervention from the Office of General Counsel, you must keep this standard in mind since it will be the standard by which the evidence in the referral will be evaluated.

"Beyond a reasonable doubt" – The highest standard of proof required for any criminal action taken by law enforcement under the Adult Protection Act pursuant to T.C.A. §§ 71-6-117 or 71-6-119, or under some other criminal statute. This means that every element of the crime must be proven to a degree that a person could come to no other reasonable conclusion. It does not mean "beyond all doubt".

While prosecution of a perpetrator may be an appropriate process, it is not the foremost goal of APS. Protection and safety of the client must be our primary goal and all avenues must be explored to successfully achieve that end.

With the exception of criminal actions, decisions about whether the evidence satisfies the applicable legal standard will ultimately be determined by the Department's attorney

Courts of Jurisdiction T.C.A. 71-6-114

The law gives jurisdiction of APS cases to the chancery and circuit court. In Shelby and Davidson Counties the probate court also has jurisdiction along with the circuit and chancery courts. An emergency petition for removal of a client can be brought in general sessions court if neither a chancellor or circuit judge is available. All subsequent proceedings after the emergency removal order is entered by the general sessions court must be conducted in chancery or circuit court. T.C.A. 71-6-107(a) (1) (B)

In practice the chancery court is the court of preference (first choice) unless the chancellor is not accessible and there is need for an emergency order. When the

chancellor is not readily available and a delay in obtaining the order increases the risk to the client, then circuit court will be used. Probate court may be used in Shelby County when the delay created by using the other courts would increase the risks to the client.

Venue – This refers to the location where a court proceeding can be commenced pursuant to a statutory provision. Under T.C.A. § 71-6-114, a proceeding may be commenced in the county where the client resides or is physically present.

Legal Authority for Assistance with Investigations

Search Warrant

A search warrant may be obtained to aid the investigation of any case in which there is probable cause to believe a client is being abused, neglected or exploited. Enter Private Premises to Investigate - T.C.A. 71-6-103(f)

When Used:

Most frequently used to complete an investigation when unable to gain access to the client because the client is unable to consent to entry or a caretaker refuses to allow staff to enter the premises where the client is located to conduct the investigation.

Requirements:

- A referral of abuse, neglect or exploitation of an impaired client and "probable" cause to believe that A/N/E is occurring or has occurred.
- The inability to complete or begin the investigation due to the client's or another person's refusal or inability to allow entry or access.

NOTE: A search warrant obtained by the Department must be executed with the assistance of a law enforcement officer.

"Probable cause" to obtain a search warrant means that the factual circumstances in which the client is found are such as to make a reasonable person believe that it is more likely than not that the client lacks the capacity to consent and is being abused, neglected or exploited.

NOTE: Conclusive proof of lack of capacity and imminent danger are not required for search warrants since the purpose of the warrant is to assist in making those determinations.

Orders for Mental or Physical Examinations - T.C.A. 71-6-103(*l*).

To obtain an order for a mental and/or physical examination of an client when the available evidence is insufficient to establish the client's lack of capacity or imminent danger to the client, the Department must demonstrate that there is "probable cause," as described above, to believe that a client lacks capacity to consent to protective services and is being abused, neglected or exploited.

A request for a court-ordered mental or physical examination will require notice to the client unless there is cause to believe, and the court finds, that the client is in imminent danger and that delay for a hearing would likely substantially increase the client's likelihood of irreparable physical or mental harm or both, and/or the cessation of life.

This type of legal intervention provides for a minimal level of intervention in the investigative phase of the case, but enables additional, needed information to be obtained to make a determination regarding the factual basis for further legal action to seek an order to provide protective services. This is particularly critical when potentially life-saving decisions need to be made.

Examination orders obtained under T.C.A. § 71-6-103(*l*) provide only for examination of the client to the extent necessary to determine lack of capacity to consent to protective services and/or to determine imminent danger due to the client's physical condition or mental condition and do not permit the Department to consent to further treatment or placement of a client beyond the scope of those examinations without first obtaining an additional order from the court.

Additional authority to obtain longer term placements will typically require the initiation of a complaint for protective services in which custody of the client is granted to the Department**.** The client may be hospitalized only for the examination, in those situations when the needed examination requires the client to be hospitalized.

In many instances the information regarding capacity and imminence of danger may already be available in the observations of the counselor or other persons which will enable the Department to make a reasonable decision regarding the client's capacity to consent and/or imminence of danger. When such information is already available, but on only one criterion necessary to seek legal intervention and not the other, then the Department may request court authority to obtain the examination / evaluation needed to give us the additional information.

Necessary Conditions for Court Intervention

Any time there is reason to question whether or not a client is in imminent danger, the client's capacity to make decisions must be carefully reviewed. In order to determine whether or not legal intervention is warranted, counselors must always obtain supervisory and legal consultation regarding the client who is refusing life saving services.

Injunctive Relief – T.C.A. 71-6-104

When Used

Temporary restraining orders (TROs) and temporary and permanent injunctions can be used in APS cases when needed to ensure the protection of the client or aid in the Department's investigation.

A TRO can be issued immediately by the court without a hearing to stop imminent or continuing harm to the client by an abusive caretaker or other person or to prevent a caretaker or other person or entity from interfering with either the Department's investigation or the provision of protective services. A temporary or permanent injunction requires a hearing but provides the same protection as a TRO and can also direct a person to do something such as provide care or divulge information regarding a client's resources.

The court may also enjoin from providing care for any person, on a temporary or permanent basis, any employee or volunteer, who the court finds has engaged in the abuse, neglect or exploitation of a client. This applies to situations in which the employee or volunteer is involved in the case of a client. An injunction can be requested whether the abuse, neglect or exploitation occurred in an institution, group homes or foster homes and whether or not the person or entity is licensed to provide care for clients.

The permanent or temporary injunction can also provide the necessary due process to an alleged perpetrator of abuse, neglect, or exploitation to allow release of an indication to an employer or other entity with whom the perpetrator is associated in order to provide protection to a client or other vulnerable clients who are under the care of the alleged perpetrator.

Consultation with the supervisor and DHS attorney is required to use injunctive relief for this purpose.

Capacity to Consent - T.C.A. 71-6-102(11)

For court-ordered protective service, whether those services are to be provided in the client's home without the Department having legal custody of the client or whether legal custody must be obtained to provide those services, evidence must exist to support the finding that the client "lacks capacity to consent" to the provision of protective services.

"Capacity to Consent," as defined in the law, means:

> The mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment

upon such facts. A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent. T.C.A. 71-6-102(11)

Non-Custodial Legal Intervention to Provide Protective Services
T.C.A. 71-6-107(b)

The law provides for court intervention on behalf of a client who does not consent, or who withdraws his / her consent, to services when the Department determines that the client is in need of protective services and lacks the capacity to consent to protective services, but the need for services and the client's physical / mental status do not legally support seeking legal custody of the client to provide services.

For a non-custodial petition, the client must:

- Be in need of protective services; and
- Be shown to lack the capacity to consent to protective services; and
- Resources and a way to administer those resources must be available to provide the protective services

Orders granting the authority to consent to protective services, but which do not grant custody of the client to the Department, are appropriate:

- In an on-going case in order to obtain authority to consent to services when the client is not at risk of imminent irreparable harm or death. This may be a situation in which the caretaker of the client is unable or refuses to provide services to maintain the client's health or safety. It is typically used to authorize in-home services.
- While APS may be authorized to consent to medical care pursuant to this type of order, it applies only to those cases in which the client lacks the capacity to consent, but is actually not refusing medical care – for example, a client who consented to the hospitalization, but is now incapable of consenting (coma, etc.) and needs tests, or surgery. If the client has always refused medical care when he / she had the capacity to do so, then a court order for custody is needed before DHS can impose treatment upon the client.

Notice and Right to Counsel

In a case in which the Department files a complaint to obtain an order to permit the Department to provide protective services to the client without taking legal custody of the client because imminent danger of harm does not exist, the client *and* spouse must receive a copy of the complaint 10 days prior to the hearing,

absent a showing of good cause. Failure to notify the spouse can lead to financial sanctions against the Department.

Guardian Ad Litem

The Department may ask, or the court may, on its own, appoint a guardian ad litem for the client.

The guardian ad litem's duty is to impartially report to the court on the client's circumstances and to represent the client's best interests. If the client is indigent, the Department is authorized to pay the fee of the guardian ad litem- T.C.A. 71-6-07(a)(4)(D)

Custodial Legal Intervention to Provide Protective Services - T.C.A. 71-6-107(a)

The law provides for court intervention on behalf of a client who does not consent, or who withdraws his / her consent, to services when the Department determines that the client is in need of protective services and lacks the capacity to consent to protective services and that the client is in "imminent danger" if the client does not receive those services.

Imminent Danger – T.C.A. 71-6-102(9)

"Imminent danger" is defined in the law as:

> Conditions calculated to and capable of producing, within a relatively short period of time, a reasonable probability of resultant irreparable physical or mental harm and/or the cessation of life if such conditions are not removed or alleviated**.**

Requirement to Exhaust All Practical Alternatives to Custody

Prior to filing a complaint with the court for an order authorizing removal of a client from his or her chosen place of residence, the Department must make reasonable efforts to exhaust all practical alternatives to the removal of the client from the chosen residence. T.C.A. § 71-6-107(a)(1)(A). These efforts may include, but are not limited to, seeking the assistance of appropriate relatives or other appropriate persons to provide care for the client and services in the home such as home health or meals on wheels, or seeking a non-custodial order to provide protective services in the home.

Once reasonable alternatives have been exhausted, a court order can considered for a wide range of situations and at any point in a case when an immediate custody order is needed in order to address a client's urgent need for

protective services such as medical treatment, hospitalization, surgery, nursing home care, protective residential / foster care placement, etc.

The decision regarding the type of legal intervention required by the case and the corresponding degree of imminent danger will be made through supervisory and legal consultation.

NOTE: If the Department does not believe custody is appropriate or cannot establish sufficient evidence to obtain a custody order due to abuse, sexual abuse, neglect or exploitation of the client, other legal options may be considered after discussion between the counselor, supervisor and the staff attorney. These may include injunctive relief or an order of protection for the client.

Obtaining Legal Custody to Provide Court-Ordered Protective Services

When the Department makes the decision to seek an order granting the Department custody of a client to provide and consent to protective services, the DHS attorney will draft the petition to file with the court and the following action will be taken:

- The Department will file a complaint with the court for an order authorizing the immediate provision of protective services necessary to prevent imminent danger of harm or sexual abuse to the client;

- The chancellor or judge will, as stated in T.C.A. § 71-6-107(a), be asked to hear the complaint ahead of any business then pending in the court or in chambers;

- The chancellor or judge, prior to entering the order, must find that the client is in imminent danger of harm or death or is being sexually abused **and** if he / she does not receive protective services and that he / she lacks the capacity to consent to protective services.

- Within seven (7) calendar days (if the 7th day falls on a weekend or holiday it will be the following day) or up to 15 days for good cause shown, of entering such an order, the court must hold a hearing on the merits of the case. If the hearing is not held within these time frames, the order will be dissolved.

Notice and Right to Counsel

Failure to notify the spouse can lead to financial sanctions against the Department. Therefore, it is important that information be obtained regarding the whereabouts of a spouse who is absent from the client's home or does not visit the client in a placement or who is not living with the client.

Authority under an Emergency Order for Custody

Emergency custody orders may give the Department the temporary authority prior to a final hearing on the merits of the Department's case to consent to medical examinations, treatment and/or placement of a client depending on the needs of the client and on the type / level of danger to the client. Typically, serious actions involving very risky surgery or amputations must be delayed until a final hearing.

Before a final hearing is held on the Department's complaint, the court must authorize any additional services which many be necessary for the client which are beyond the scope of the emergency order. This will require that the Department's staff attorney be contacted to seek additional authorization for these services, or to ask that the final hearing be expedited.

Temporary Guardian – T.C.A. 71-6-107(a) (6)

A Temporary Guardian should be considered for clients who have sufficient resources and are required to pay for the court-ordered care / treatment and for those clients without resources that need arrangements to be made for indigent care / treatment. Whenever DHS seeks a custody order for a client who is unable to obtain the care / treatment he / she requires until someone is given access to his / her resources, the complaint should include a request for a temporary guardian to be appointed; or, if this need arises after the complaint is filed, the Department's attorney should be advised to ask the court to appoint a temporary guardian.

NOTE: DHS staff cannot serve as the temporary guardian for the APS client.

- The temporary guardian may serve for up to 6 months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend the appointment for no longer than an additional six (6) months.
- If the client will need someone to manage his / her affairs or have other responsibilities not addressed by the appointment of a temporary guardian or for longer than the law allows the temporary guardian to serve, then the requirements for appointment of a conservator will be followed.
- The guardian must file with the court an accounting of the resources used.

NOTE: The case must remain open during the entire appointment of a temporary guardian.

Authority under a Final Order Granting Custody / Court Authorization for Additional Service / Review of Client's Status

Once an order for custody has been issued, the Department (or other person or entity given custody) will retain custody of the client and is responsible for the client's care until relieved of this authority by the court – even if the immediate imminence of danger is relieved.

The Department's authority to provide services is limited to those authorized in the court's order. If medical or nursing staff advises of the need for additional or different services beyond the scope of the court order, the staff attorney must be immediately contacted to seek further court authority for those services.

Post Placement Examinations – T.C.A. 71-6-107(a) (b)

Clients taken into legal custody and placed in a non-medical placement must have an examination in order to determine the cause of the condition which has resulted in the client's lack of capacity to consent. This examination is always required unless such determination was made at the time of the final hearing. The purpose of this examination is to ensure that the cause of the incapacity is known and that appropriate care and/or treatment are obtained.

The required examination should be obtained within two weeks of placement. In some cases an accurate diagnosis may be completed with one examination while in others a full range of examinations and tests may be needed. These may include a neurological, a psychiatric evaluation, CAT scan, MRI, etc. Once the cause of the incapacity is determined, prescribed treatment should be arranged.

Review of the Client's Status - T.C.A. 71-6-116

When it appears that the custody order is no longer needed in order to prevent the irreparable harm to the client or to prevent the client's death or the client regains his / her capacity to consent to services, and then DHS will request a review by the court regarding the necessity for continued custody.

The court will require evidence that the client's condition has changed and that custody is no longer needed.

If, after the imminent danger has passed, the client continues to lack capacity, APS should consider the appointment of a conservator if this appointment would enable the client to receive the level of care and/or protection that is needed.

Emergency Involuntary Admission to Inpatient Treatment

When a person poses an **IMMEDIATE** substantial likelihood of serious harm to self or others if he is not immediately detained due to his mental illness or serious

emotional disturbance, he / she may be taken into custody without a civil order or warrant by an officer who is authorized to make arrests, or by a licensed physician, or by a licensed psychologist who has a health service provider designation. The custody is for the purpose of immediate examination for certification of need for care and treatment.

Nonemergency Involuntary Admission to Inpatient Treatment – Judicial Commitment

Requirements for Legal Action

- The person is mentally ill or seriously emotionally disturbed;
- The person poses a substantial likelihood of serious harm because of mental illness;
- The person needs care, training, or treatment because of the mental illness; and
- All available less drastic alternatives to placement in a hospital or treatment resource are unsuitable to meet the needs of the person.
- A certificate of need from two licensed physicians or one licensed physician and one licensed psychologist who has been a health service provider must accompany the petition.
- The professionals must have examined the individual within 3 days from the date on the certificate.
- A petition for judicial commitment must be filed:
    - By the parent, guardian, spouse, or a responsible relative of the person alleged to be in need of care and treatment, a licensed physician, a licensed psychologist who has a health service provider designation, a health or public welfare officer, *i.e.* a DHS official, an officer authorized to make arrests in Tennessee, or the head of any institution in which the person is located,
    - In the county where the individual is located, the county of residence or, if the individual has been hospitalized under T.C.A. § 33-6-103, in the county where the client is hospitalized.

Process

The need for judicial commitment should first be brought to the attention of an individual who is authorized to file a petition in order to encourage him / her to seek appropriate help for the client.

If no other person who is authorized to file a commitment petition can be located, or if the person does not agree to do so, the petition can be filed by APS when appropriate and consistent with APS policy.

The client should, whenever possible, retain the services of an attorney. If legal assistance is available in the county, they may be referred to a legal services office. A person who is unable to retain an attorney and is unable to receive free legal services may wish to go to the judge and explain the situation and request the court's assistance in referring the person to an attorney.

- If one of the above named individuals is willing to seek the help needed by the client, but needs assistance with services, APS may assist by providing referrals, transportation or other services which enable the client's need to be met.
- If APS is unable to find help for the individual and or is unable to obtain the client's agreement to leave his / her home or to see a doctor, legal action should be requested. The action may be judicial hospitalization under the mental health laws or other remedies available under the Client Protection Act.
- A request to file a petition under the mental health law must be approved by the FS1, Program Supervisor and APS State Office before being submitted to the Office of General Counsel for consideration of legal action.

Referral to DHS Attorney for Non-Emergency Judicial Commitment

This process does **not** involve the emergency procedures for commitment for evaluation as described above.

There are form petitions for involuntary commitment, both emergency and judicial, available from the Tennessee Department of Mental Health and Department of Intellectual and Developmental Disabilities, crisis teams and regional mental health institute attorneys.

Referrals recommending legal action to obtain judicial hospitalization of clients should be prepared in triplicate and routed to the Program Supervisor for approval.

After approval, the original should be transmitted to the Office of General Counsel in the State Office and a copy to the DHS Attorney for the District for review to determine if legal action is appropriate.

If consultation with the Adult Protective Services staff in the State Office is requested, one copy should be transmitted to the Program Director.

The referral should include the following information in the order listed:

- Name, address and age of the client in need of hospitalization.
- Whether or not the client has ever been committed to a mental health facility by the court and whether he / she has been released from the hospital**.** This information can be found in the court records in the county where he / she was committed.
- Name and address of conservator or attorney in fact with durable power of attorney for health care if such has been appointed.
- Name and address of the two certifying professionals – either two physicians or one physician and one psychologist – who examined the client and certified the client's need for hospitalization for mental health treatment.
- Include the date of the examination. If the client has refused to be examined by a physician for purposes of certifying the need for mental health treatment, then reasons for believing the client is mentally ill or seriously emotionally disturbed and poses a "likelihood of serious harm" must be described so that an order for the examination can be sought pursuant to T.C.A. § 33-3-607. Also, a statement must be included describing all efforts to use all other less drastic alternatives to commitment to a mental hospital or treatment resource and why these alternatives are unsuitable.
- Include specific indications of the clients "substantial likelihood of serious harm" as defined in the section on judicial commitment.
- Name and addresses of the individual's parents, spouse or next of kin.
- Name and address of witnesses, their willingness to testify and the relevant facts each can attest to from their own personal knowledge.
- Include preliminary indications of the ability of the client to secure legal representation.
- Date of referral, name and title of the counselor and supervisor.

Filing of the Petition

Courts having jurisdiction may differ according to the size of the county. It is most frequently the Circuit Court, but may also be Chancery Court, Juvenile Court or Probate Court. The staff attorney for each District will have to determine the appropriate court in the county. See T.C.A. § 33-3-603.

Venue for Filing a Petition

The petition must be filed in the county where the individual resides or is located. This may be the county of residence or, if the individual has already been hospitalized under T.C.A. § 33-6-103, it will be the county where he /she is hospitalized. See T.C.A. § 33-3-603.

After Petition is Filed

Upon filing the petition, the court shall give notice to the individual of the time and place of the hearing. Notice shall also be given to the individual's parent, guardian, spouse or other next of kin, and the head of any institution in which the individual may be residing.

The hearing shall be set for a time as soon after the filing of the petition as the business of the court will allow, but not more than twenty (20) days from the date the petition was filed. A continuance may be granted for ten (10) days if good cause is shown.

The individual can retain, or the court may appoint, counsel to represent the individual in these proceedings.

The Hearing

The individual for whom the petition is filed, the petitioner, and all other persons required to receive notice shall have the opportunity to appear at the hearing and to testify.

Both the petitioner and the individual, as represented by counsel, may cross-examine witnesses. The court, in its discretion, may receive the testimony of any other person. The court shall determine the place of the hearing. An examining professional is a compellable witness at the hearing. 33-3-504.

The testimony of a certifying professional may be made by deposition or affidavit with the consent of the individual or his counsel.

The Order

Upon completion of the hearing, the court must find by clear, unequivocal and convincing evidence that the individual meets the judicial commitment standards and can, therefore, commit the individual to a hospital or treatment resource.

If commitment is to a state hospital, the individual may be admitted when the hospital has suitable available accommodations. Some private facilities, when payment arrangements have been made, take judicial commitments.

If the court finds otherwise, it shall terminate the proceedings, dismiss the petition and release the individual unless he is being held under the provisions of some other law.

Use of the Adult Protection Act by Other Agencies T.C.A. 71-6-107(a)(7)

If the Department declines to file a petition under the Adult Protection Act, the law permits a private non-profit agency representing disabled clients to petition the court for an order granting the right to consent to protective services on behalf of a client who lacks capacity to consent and is at imminent risk of irreparable harm or death. Such a petition would require:

- Notice from non-profit agency to DHS of intent to file the petition;
- Notice by APS staff to the APS supervisor and DHS legal staff of an impending petition being filed under the Act;
- TDHS to assume the responsibilities specified in a court order, including custody of the individual, if the court finds that an order authorizing protective services is warranted, and DHS is ordered to provide those services. The Department's responsibilities would then be the same as if the Department had been the petitioner.

If the court finds that an order granting custody is not warranted, then the petitioning agency will be responsible for the cost of the court appointed attorney for the client and the court costs.

Civil Remedy – T.C.A. 71-6-120

The Department of Human Services is not required to initiate any legal action to seek recovery of damages on behalf of the client. APS staff can share with APS clients, family members, or legal representatives the information about this additional legal option available to victims. It is also appropriate to provide a referral to legal services providers or other attorneys for victims who may wish to pursue this option. Information / documents from APS records can be made available for this purpose.

Conservatorship T.C.A. §§ 34-1-101; 34-2-101; and 34-3-101 et. seq.

When APS becomes involved with a client who appears to be unable to manage himself, his property, or both, the Department may provide legal services to establish a conservatorship under certain, defined circumstances.

The Department will not seek to have any Departmental staff or other state employees, except District Public Guardians, appointed as a conservator.

A decision for the Department to act as the petitioner to establish a conservatorship will be made on a case by case basis, and will be the exception for provision of legal services to a client as part of the Department's responsibilities under the Adult Protection Act.

Although the conservatorship law permits a hearing in a shorter period than the usual seven (7) minimum/sixty (60) maximum day time frame for holding a hearing when the person is faced with a life threatening situation, because this time frame must be waived by the court, conservatorships may not be as effective in obtaining emergency protective services for an client to prevent imminent harm to the client. Therefore, the use of a conservatorship must be carefully considered before being used as a substitute for a complaint filed seeking emergency temporary custody under the Adult Protection Act.

Requirements:

If a conservatorship is sought initially instead of custody under the Adult Protection Act, the referral should substantiate the individual's lack of capacity and the risk of imminent irreparable harm or death.

The referral should clearly describe how the establishment of a conservatorship is a more appropriate means of providing protective services than seeking custody by the Department under the Adult Protection Act.

For a client who is already in the Department's custody under the Adult Protection Act, the referral should substantiate the client's on-going lack of capacity and describe how a conservatorship will be an effective transition to the provision of long-term services, including, if necessary, the management of resources, for the client.

Legal Referral

To file for a conservatorship for a client the legal referral must contain the following basic elements:

- The name, birth date, address and current location of the client if different from the home address;

- The specific authority to address the client's care and financial circumstances that are being requested from the court and a request for the appointment of a specific person to act as conservator pursuant to the court's order

- Specific examples of the conditions and circumstances of the abuse, neglect, or exploitation which make it necessary to seek legal action due to imminence of harm or death to the client if the conservatorship is to be

used to provide services in lieu of a complaint under the Adult Protection Act;

- Evidence and an explanation of the need for protective services due to lack of capacity and imminence of irreparable harm or death if the conservatorship is to be used to provide services in lieu of a complaint under the Adult Protection Act; or

- Evidence and an explanation that the conservatorship is a means of making a transition, if applicable, from custody of the client by the Department under the Adult Protection Act to the long-term care and supervision by a suitable relative or other suitable person or conservator; or

- Evidence that other extraordinary circumstances involving the need to protect the client from imminent harm and to provide protective services to the client make the use of a conservatorship clearly more appropriate for the particular situation.

- A copy of a sworn medical examination of the client and any other medical evidence to show the client is unable to care for him / herself and/or manage his / her property and finances, or a statement that the client has been examined but no report has been received, or a statement that the client has refused to be examined voluntarily, with a request that the court direct the client to undergo a medical examination to determine the need for a conservator for the client

- The name and address of the client's physician, psychiatrist or psychologist;

- Specific evidence of the client's "lack of capacity to consent" under the Adult Protection Act if the conservatorship is to be used to provide services in lieu of a complaint under the Adult Protection Act;

- The full names, addresses and telephone numbers of witnesses and the particular facts each will be able to testify to from his / her own personal knowledge.

- A statement specifying whether or not the client has ever been committed to a mental hospital; if so, what hospital and when;

- The name and address of the proposed conservator: The Tennessee District Public Guardian may be considered for appointment for clients age 60 and over;

- Relationship of the proposed conservator to the client, if any;

- A statement from the proposed conservator's willingness to serve, and an explanation of why the person proposed is appropriate to be the client's conservator since that person will be responsible to the court for the management of the client's physical well-being and the client's resources;

- Preliminary indications of the financial ability of the client to secure legal representation and to provide all other necessary expenses of representation in the court proceedings, as well as the client's ability to pay for the services requested and an explanation of the resources that are available to the client that the conservator will be required to manage;

- A list of all financial information and property or statement that the information is unknown and why;

- The name and address of any payee for Social Security (SSA), Supplemental Security Income (SSI) or other benefits which may exist;

- The name of anyone with an existing power of attorney for the client;

- Name and address of the client's "closest relative(s)" so that notice can be given to that person by certified mail;

- Name and address of the person with whom the client is living and/or name and address of the person who has custody of the client if applicable;

- A statement specifying what rights are to be removed from the client;

- The specific service plan for the client and how the proposed plan will enable the client to be protected;

- Date of referral, name and title of counselor and supervisor;

The conservatorship petition may be filed in any court with probate jurisdiction, generally, probate or chancery courts. This will vary by county. It must be brought in the county of the person's residence. 34-3-101

The person for whom the conservatorship is being sought has a right to counsel. 34-3-106. If the court finds that the person needs a conservator, the court's order will detail the rights to be removed from the client and the rights being granted to the conservator. 34-3-107.

Domestic Abuse - T.C.A. §§ 36-3-601, et seq.

DHS will only serve as petitioner in those cases in which the client is unable to act in his / her own behalf and DHS has been given authority to act in his / her behalf under a court order.

In other instances, the client, or someone who may assist the client, may be referred to the court clerk or court for assistance under the Domestic Abuse Act.

How to Obtain an Order of Protection

- Petition to the court for an Order of Protection based on the abuse or threat of abuse of a client by a present or former household member.

- Actions seeking an order of protection can be filed in a court with domestic relations jurisdiction, usually a circuit or chancery court, or a general sessions court, but also, in absence of a judge of those courts, may be obtained from judicial commissioners, magistrates and other officials with authority to issue an arrest warrant

- The necessary forms to seek a protection order are available from the clerk of the court upon request. The clerk of the court will give any necessary assistance to the client, who is not represented by an attorney, in completing or filing the forms to petition the court. The client is not restricted to the use of the forms provided by the court. Any legally sufficient petition may be acceptable.

- The Act allows the client who wishes to file a petition for a protection order to do so even when their income is so limited that they cannot afford an attorney, the filing fee, or litigation tax. Since many of the clients referred to the Department have limited income or in some instances no income, this provision should eliminate a barrier for those clients who would be financially unable to file a petition if an attorney, filing fee, or litigation tax were required.

Process concerning the Department's Role in Domestic Abuse Situations

- Share information with the abused client regarding the available options under the Domestic Abuse Act when it is believed that a protection order will enable the client to be protected.

- Refer the abused client to the local domestic violence agency or local court with jurisdiction over domestic relations matters.

- APS staff will not render legal advice or complete the forms for an Order of Protection for the client except when authorized by the court.

- Provide assistance as is necessary to assist the client with gaining access to the court. Since the court provides the form and assistance in

completing and/or filing the form, this should be beneficial to the client who may otherwise become lost in the process without assistance.

- In a situation in which the Department has alleged and provided sufficient proof to the court that a client lacks the capacity to consent to protective services, *and the court has authorized the Department to provide protective services on behalf of the client*, the Department may then consider petitioning the court as "next friend" using the Domestic Abuse Act (T.C.A. §§ 36-3-601 through 621) to request an order of protection for the client who has been abused by a family or household member.

Orders of Protection Filed by Relatives of the Client

In 2010, the legislature passed Public Chapter 898, which became effective on May 10, 2010 authorizing relatives of an adult to seek orders of protection in situations where the adult may be suffering from abuse, neglect or exploitation as defined in the Adult Protection Act.

A relative is defined under the Act as: spouse; child, including stepchild, adopted child or foster child; parents: including stepparents, adoptive parents or foster parents; siblings of the whole or half-blood; step-siblings, grandparents, grandchildren, of any degree, and aunts, uncles, nieces and nephews.

The Act adds a new section, T.C.A. § 71-6-124 to the Adult Protection Act setting forth the requirements for filing for a petition for an order of protection and the authority of the court to issue orders, including injunctive relief to protect the adult from A/N/E and to order the return of any funds that have been misappropriated.

The orders are effective for 120 days and can be extended if necessary.

Written notice of the filing of the petition for an order of protection and copies of the petition and the ex parte order of protection against the perpetrator, if any, shall be sent by certified mail, return receipt to the APS unit in the county office of Department in the county in which the petition is filed. This is so that the Department can be made aware of allegation of A/N/E and, if necessary, investigates those. If an investigation is initiated, and if further action to provide protective services is warranted, the Department has the right to intervene in the order of protection proceeding, but shall not otherwise be required to initiate any legal action as a result of having received the notice of the filing of the petition for an order or protection.

The Department may, at any time, file a petition pursuant to § 71-6-107 for custody, or to provide protective services to the adult without assuming custody, if it determines that the adult who is the subject of a petition for an order of protection is in need of protective services.

Appendix H
DOCUMENTATION PRACTICE GUIDE

Case Files

It is essential that the APS case files accurately reflect what has transpired with a client who is receiving services from DHS. A full picture of the investigative, assessment and service activity with the client will enable staff to:

- Engage in appropriate case planning,
- Document APS response times and contacts;
- Document the services provided to the client (which is necessary for fiscal and legal accountability),
- Provide an accurate source of information when legal action is taken,
- Assure continuous services during counselor absences or vacancies, and
- Aid supervisors and program staff in responding to requests for case consultation.

Any activity or information that is used to fully evaluate the client's condition and needs should be included in the case recording. Any information obtained or observations made which are used in case planning and decision-making must be included in the recording.

Any changes related to service needs which occur during APS involvement with the client must be reflected in the case recording and case assessment. The purpose of case recording is to substantiate the counselor's actions and conclusions. It should support the information recorded on the Safety Assessment and Outcome Measurement.

Characteristics

Case recordings should be concise, factual, objective, relevant and reliable.

- Concise means comprehensive, but free of unnecessary words.
- Factual requires accurate information about what occurred, was observed, was said, or was decided and when, exactly, a condition or circumstance was observed or a statement was made by a witness or by the client.
- Objective means neutral and unbiased information and does not include any assumptions or opinions. Because of the nature of APS, case files may be subpoenaed by court as evidence or be the subject of discovery procedures in a legal action involving the Department; therefore, speculation, gossip, conclusions, and assumptions based on insufficient

facts should be avoided. Opinions and conclusions based on fact are sometimes essential for explaining case decisions; these should be given with the supporting facts.

- Relevant means that the information provided pertains to the allegations of the report or other risks which are to be addressed. The record should be free of extraneous observations / comments that are not necessary to the description of injuries, conditions or events.

- Reliable means accurate, timely information free from subjective interpretations of the facts, with clearly labeled and attributed quotes. Judgments and opinions should be labeled as such with their supporting evidence.

- Medical information must always be attributed to the source; labels or diagnoses should not be used unless furnished by a medical professional. Medical information **must** consist of **specific facts** regarding the adult's condition as observed by medical / mental health professionals. The medical information obtained by the Social Counselor must give specific medical or mental health conditions. When legal action is being considered, the **counselor must request the medical / mental health personnel to describe how the existence of a condition, or the combination of conditions, places the adult in danger or harm and how imminent the harm to the adult will be if those conditions are not alleviated within a relatively short period of time**. *It is not enough* to say that the adult would be better off if removed from the home or not sent home with a relative of questionable caring skills. Conclusory medical / mental health opinions **without supporting <u>facts</u>** may not support legal action when a legal referral is sent to OGC legal staff and may be insufficient to sustain legal action by the Department in court.

  If sufficient facts are not included with the referral, the counselor will be asked by the Department's attorney to return to the medical / mental health personnel to secure factual statements to support the allegations of harm to the adult for any legal action that is requested seeking custody or conservatorship of the adult.

- Opinions or remarks may be included if enclosed in quotation marks and the source indicated.

- Facts are straight-forward, known or observed activities, circumstances and decisions. They may also be information drawn from official records or documents.

- Observations are recorded notes of another individual's behavior or circumstances as seen by you or reported to you by others. In recording observations, the source of the information must be clear.

- Interpretations are conclusions or opinions based on gathered facts and observations. Interpretations require ample evidence to support them.
- Interpretations of another person's statements and behaviors must be identified as such and not recorded as facts.

Appendix I
CASE CLOSURE PRACTICE GUIDE

When cases are closed after the investigation process because the client's level of safety has improved or because the client refused on-going intervention, it is important for APS to review whether or not a perpetrator has been indicated and whether it is appropriate and desirable to seek an injunction against an indicated perpetrator before the case is closed.

After on-going services have been provided, it is important that APS only close a case because the client's level of safety has improved or because the client, if the client has capacity, has decided to refuse additional services. If the client's level of safety has not improved, but the client decides to decline additional services, it is important that APS staff document the client's capacity to make this decision.

Decisions Regarding When to Close a Case

Closure of a case is a critical decision point. This decision may be made after investigation or it may be made after on-going services.

Investigation Closure

The decision to close a case after investigation is an important decision in which the Social Counselor will weigh all of the information obtained during the investigation. This includes all the evidence gathered as it relates to the allegations in the referral and any other information about the client's circumstances obtained in the investigation that may not have been addressed in the referral. The decision to close will involve the safety and needs of the client. In addition, one must also be mindful of the client's right to self-determination and his / her capacity to refuse protective services, particularly when concerns regarding the client's safety arise during the investigation, and the client refuses continued services.

When a Social Counselor has made the decision to close a case after investigation, the Closure Safety Assessment and Outcome Measurement must have been completed, clearly identifying the client's functioning at the time, as well as the needs of the client and any available support system. The Social Counselor should carefully review the levels of safety in each domain that were evaluated and in the closing summary.

On-Going Services Case Closure

The decision to close a case after on-going services is an equally important decision point. It is often a difficult balance between awareness of the client's

circumstances and understanding when APS intervention is no longer needed. This can be particularly difficult when a Social Counselor has a relationship with a client that will be hard to sever. Many times, APS staff and the client have formed a bond, but the critical issue is whether the client continues to need APS services.

For cases in which on-going services are being provided, the Periodic Assessment is conducted when a case remains open for 6 months from the Post Investigation / On-Going Services Assessment. This Periodic Assessment allows for documentation of any changes occurring in the client's level of safety since the preceding assessment. When a Social Counselor is beginning the process of deciding to close a case, it is important to review the Periodic Assessments. Special emphasis should be placed on evaluating the degree of successful reduction in previously identified risks and by which service alternative / intervention the reduction was achieved.

The decision to close will involve the safety and needs of the client. In addition, one must also be mindful of the client's right to self-determination and capacity to refuse protective services, particularly when concerns about the client's safety arise during the investigation and the client refuses continued services.

If previously identified risks have been fully addressed, and no new risks have been identified or the client refuses continued services and has the capacity to do so, then closure of the APS case should be completed.

Closing an APS Case with Continuation of Protective Services Homemaker Services

Under appropriate circumstances, a case may be closed for Adult Protective Services, but continue as a Protective Services—Homemaker only case. Everyone who would benefit in some way from Homemaker Services will not need Homemaker Services as a Protective Service.

The client must meet the criteria for Protective Services, and the record must reflect the ways in which Homemaker Service will meet all identified protective needs. If there are other protective needs which cannot be met through Protective Services—Homemaker Services, then the case must remain open for Adult Protective Services. If the case is closed, but Homemaker services continue to be provided, explain the rationale for the case decision that no additional services are needed to ensure the client's safety and how the level of safety improved with the existing provision of Homemaker Services.

Appendix J
HEALTH AND SAFETY PRACTICE GUIDE

In the performance of the job, APS staff frequently encounters clients and families who are in crisis situations, who may become angry or hostile. Most individuals do not present a danger to the counselor but there can be some instances in which individuals or situations may pose a physical threat. However, the counselor can use strategies and techniques to help defuse anger and hostility and enhance the working relationship.
Following are guidelines and indicators to help:

- Deal effectively with crises and hostility - take reasonable steps to defuse volatile situations and maximize safety, and
- Recognize signs and signals for immediately leaving the premises.

General Safety Precautions

Following are some good practices for general safety which staff should routinely follow when going into the field.

- If you are uncomfortable about the visit or anticipate problems, if feasible, ask a coworker to accompany you.
- Be aware of your surroundings; identify “safe spots” in the area.
- Look around before getting in or out of your car.
- Lock your car doors while driving and when you leave your car.
- Before leaving your home / office, lock valuables such as wallet and purse in the trunk.
- While walking to your car, have your keys ready in your hand.
- Avoid looking down or digging in your purse / briefcase while walking.
- Make sure you have plenty of gas to get to your destination(s) and back.
- Ask for clear, specific directions before you leave.
- Take your cell phone with you in case you need it.

Threatening Situations

When coming into an unknown or questionable situation:

- Scan the surroundings to establish the location of exits, etc.

- Sit or stand in a position where your back is to the wall, where you can see the door, and there is no other person between you and the exit. Facing the door usually means that you are facing another person who will be between you and the door.

- Sit or stand so that you do not invade the other person's personal space.

- Personal space is the area around a person's body into which others may not come.

    - Intrusion into that space increases anxiety and may be perceived as threatening.

    - APS intervention may stir strong feelings of fear, anger, etc.

    - Some individuals may respond by verbally venting. Anger may escalate to the point of shouting or swearing. While this may be very uncomfortable for the counselor, most persons will experience a release of tension if allowed to vent, and will then return to rational thought. If the person being interviewed becomes loud, argumentative, sounds angry:

    - It varies from person to person, with the relationship between individuals at a given time, and is influenced by culture and socialization.

    - The APS counselor will need to adapt to the other person's personal space, especially if it is a greater distance than that of the counselor, *i.e*., if the person moves back, allow the greater distance and do not move closer.

Do –

- Keep calm and maintain a lower voice volume;
- Be aware of your body language and non-verbal message;
- Observe the other person's body language and nonverbal behavior;
- Allow the speaker to vent and show you are actively listening;
- Acknowledge the speaker's feelings;
- Remain respectful toward the speaker.

Do not –

- Take it personally or become defensive;
- Raise your voice to match the speaker;

- Interrupt or attempt to reason with the person while he / she is actively venting;
- Become argumentative or engage in a verbal power struggle;
- Touch the individual or enter his / her personal space.
- Attempt to respond to the outburst until it has subsided. Individuals that are yelling, etc. cannot hear nor can they think rationally. Interrupting to respond may aggravate the individual more and escalate the situation. Wait until the individual has quieted down before attempting to respond. It is of utmost importance to respond non-defensively.

If the person makes physical threats, becomes increasingly irate despite the counselor's efforts, or becomes physically intimidating, it is appropriate to conclude the interview and leave. Investigative activities / services, etc. will continue and contacts can be made at another time.

No APS counselor should remain in a situation that constitutes a dangerous situation. In the event that there is an incident related to a threatening situation, an Employee Safety Incident Report must be filed. If the employee incurs an injury or health-related condition that requires medical care, the employee may be eligible for compensation. See the Workman's Compensation section below for procedures for filing claims for loss / damage to property or for medical care.

Encounters with the Production and use of Methamphetamine During Investigations

The production and use of methamphetamine (meth) poses serious risks for APS staff and clients. This section contains information about meth in the following areas:

- General information about methamphetamine;
- Recognizing the physical signs of a meth production site;
- The risk to personal safety that the meth user may present;
- Hazards from the environment to the APS staff and to the client;
- Protocol for APS with law enforcement.

If a referral is received and there is a reference to possible methamphetamine production or use, DO NOT go out on the referral without taking steps for your protection. Immediately contact your supervisor to plan for taking personal safety precautions and involving law enforcement.

Staff Exposure to Methamphetamine

In the event that staff is exposed to methamphetamine, there are some possible physical side effects which may occur. They are:

- Headaches,
- Nausea,
- Shortness of breath,
- Fatigue,
- Chest pain,
- Dizziness,
- Lack of coordination,
- Tissue irritation,
- Contact burns.

If a staff person exhibits these side effects, it is important to notify the supervisor and follow the Workers Comp procedure, unless the effects or injury are so critical that emergency medical treatment must be obtained before that procedure can be completed. In this case seek immediate medical care and follow-up as soon as possible with approval of treatment through the Workers Comp process.

General Information about Methamphetamine

Methamphetamine is a Schedule II drug under federal regulations, meaning it has a high potential for abuse with severe risk of causing dependence. According to the Drug Enforcement Administration (DEA), methamphetamine has been the most prevalent, clandestinely produced controlled substance in the United States since 1979.

The production and use of methamphetamine is a significant problem in Tennessee. Although it has been most prevalent on the Cumberland Plateau, it is spreading to other parts of the State. Meth is a synthetic stimulant that is produced in the form of pills, capsules, powder and crystal chunks. It is odorless. Pure meth is clear or white, although it can range in color from red to brown, depending on the chemicals used in its production and their contaminants. It can be ingested orally, absorbed as a suppository, smoked, snorted, or injected.

Meth is highly addictive. It works by artificially stimulating the reward or pleasure area of the user's brain without causing anything beneficial to happen to the body. As the pleasure center of the brain is intensely stimulated, the chemicals

released in the brain become depleted over time, so that it becomes harder and harder for the addict to achieve the desired effect.

Behaviors Associated With Methamphetamine Use

There is a high probability that, if meth is being manufactured, it is also being used at that location. Meth relieves fatigue, reduces the need for sleep, increases energy levels and in general brings about psychological and physical exhilaration. Users may go for long periods without sleep. As the drug high peaks and declines, depression sets in. The user may become agitated, experience heightened sensitivity to sound, experience hallucinations, delusions, paranoia and sudden, unpredictable mood swings, going without warning from apparent passivity to potentially homicidal rage. This individual can be extremely dangerous, especially to anyone who is perceived as a threat.

Physical / Behavioral Effects of Methamphetamine Use include:

- Increased wakefulness and physical activity;
- Increased sensitivity to sensory stimulation such as light and sound;
- Decreased appetite at times leading to extreme anorexia;
- Increased respiration, anxiety, convulsions, or hypothermia which could result in death;
- Euphoria;
- Paranoia;
- Irritability;
- Violence and aggression;
- Insomnia;
- Violent behavior;
- Confusion;
- Hyperactivity;
- Tremors;
- Agitation;
- Paranoid delusional thinking.

Other possible visible physical effects

- Dilated pupils;
- Increased pulse rate;

- Injection sites if used intravenously;
- Rigid muscle tone;
- Increased body temperature;
- Teeth grinding;
- Dry mouth;
- Talkativeness;
- Nasal redness and/or presence of small drug particles remaining in the nostrils if snorted;
- Uncontrollable movements (twitching, jerking, etc.);
- Impaired speech;
- Dry-itchy skin;
- Acne;
- Sores (may lead to severe infection);
- Numbness.

Methamphetamine addicts and users have been known to experience a phenomenon known as "crank bugs," which are chronic hallucinations in which they perceive that insects are crawling on or beneath the skin. Individuals experiencing "crank bugs" will often scratch and gouge at their skin until it breaks open, causing open sores and, possibly, severe infection.

Cardiovascular side effects

- Chest pain and hypertension (may also result in cardiovascular collapse and death);
- Increased heart rate;
- Elevated blood pressure (can cause irreversible damage to blood vessels in the brain, producing strokes).

Withdrawal effects

- Depression;
- Irritability;
- Mental confusion;
- Aggressiveness;
- Increased respiration and heartbeat;

- Defective reasoning and poor judgment;
- Weight loss;
- Anxiety and tension;
- Restlessness;
- Increased body temperature;
- Increased blood pressure;
- Dryness of lips / mouth;
- Decrease in energy;
- Difficulty in sleeping;
- Strong urges to use meth.

Environmental Hazards in Methamphetamine Production

Because meth is manufactured through the use of caustic chemicals and volatile solvents, there is a high potential for:

- Fire and explosion,
- Chemical contamination.

The lack of proper ventilation and temperature control in these homemade labs further compounds the problem. A variety of residues and solvents produced or used in the process get dumped into the ground or streams, contaminating the area and making it a hazardous waste site. Toxic vapors and gases are a by-product of the cooking process, including phosphine gas, which is a nerve gas. These gases do not totally dissipate into the air. They are deposited on and absorbed into porous surfaces, including walls, carpet, upholstery; linens etc., and are absorbed through the skin on contact with these surfaces. The degree of environmental contamination depends on how much and for how long the product has been manufactured on the site. The site will remain a hazard until it has undergone professional hazardous material cleanup.

Health Considerations for APS Staff and Client

In general, the physiological systems affected by exposure to chemicals and toxic substances will be the same for everyone. An ill, disabled or elderly adult, whose health is already fragile, may be more sensitive to this chemical exposure and experience more severe adverse effects because of existing health problems such as COPD, asthma, emphysema, high blood pressure, confusion, slower activity of enzymes that metabolize medication and toxic compounds, etc. For these individuals, there may be increased concern about the effects on their red and white blood cell counts, kidney, liver and lung / respiratory function.

Prompt medical assessment is warranted due to the risk of toxicological, neurological, respiratory, dermatological or other adverse affects of meth lab chemical and/or stimulant exposure, and the high rate of neglect / abuse in these situations.

A baseline assessment at a medical facility is needed within 24 hours of the client being found at the site due to the risk of toxicological, neurological, respiratory, and dermatological or other adverse effects from chemical exposure. The counselor will need to ensure that the physician is informed of the client's history of chemical exposure and as much detailed information as is available about types of chemicals, symptoms, initial medical findings, etc. Poison control should be called if clinically indicated.

Typical tests will include:

- Liver function tests: SGPT, SGOT, Total Bilirubin, and alkaline phosphatase;
- Kidney function tests: BUN and Creatinine;
- Baseline electrolytes: sodium, potassium, chloride and bicarbonate;
- CBC;
- Urine specimen;
- Blood pressure;
- Respiration rate;
- Heart rate / pulse;
- Other clinical evaluations at the discretion of the physician;
- Mental health screen.

The client should have a visit for follow-up care within 30 days of the baseline assessment to reevaluate the client's health status and identify any latent symptoms or need for further treatment. Following is a list of chemicals commonly used in the production of methamphetamine and the hazards which they pose:

Manufacture of Methamphetamine in Clandestine Laboratories

Meth is produced from common chemicals which can be easily obtained from hardware, farm supply, grocery and drug stores. They are chemicals that are in common home and auto repair products, cold remedies and cosmetics. Meth is cooked in kitchens, garages, motel rooms, bathrooms, cars, or anywhere a stove or hot plate can be operated. Most, although not all, meth labs are located in

secluded, rural areas to reduce the risk of detection. Possible indicators that a meth lab may be present include:

- Unusual strong odors like cat urine, ammonia, ether, acetone or other chemicals;
- Residences with windows blacked out;
- Trash piles with large amounts of empty containers from:
    - Antifreeze,
    - Cough and cold remedies,
    - Nail polish remover,
    - Drain cleaner,
    - Peeled casings from lithium batteries,
    - Aerosol cans of starter fluid with puncture holes in the bottom, etc.;
- Unusual amounts of clear glass containers — jars, beakers, flasks;
- Propane tanks, plastic coolers, paint thinner;
- Plastic tubing or hoses, used coffee filters with other residue *(i.e.*, the appearance of a home laboratory);
- Paper match books with no matches and the striker plate rubbed off.

Any of the above separately would not be cause for concern. When found in combination and close proximity, the possibility of a meth lab should be considered, and the site treated as such. Following is a list of the types of equipment, products and chemicals that are indicative of meth production:

- Iodine,
- Lead Acetate,
- Lithium Aluminum Hydride,
- Magnesium,
- Mercuric Chloride,
- Palladium,
- Red Phosphorus Sodium,
- Sodium Cyanide,
- Thionyl Chloride,

- Alcohol,
- Ether,
- Benzene,
- Toluene,
- Freon,
- Acetone,
- Chloroform,
- Anhydrous Ammonia,
- White Gasoline,
- Phenyl-2-Propane,
- Phenylacetone,
- Phenylpropanolamine,
- Iodine Crystals,
- Red Phosphorous,
- Black Iodine,
- Lye (Red Devil Lye),
- Muriatic / Hydrochloric Acid,
- Sulfuric Acid,
- Lithium,
- Sodium Metal.

Chemicals needed to manufacture meth are found in the following common household products:

- Over-the-counter cough & cold medication, bronchodilators;
- Diet Aids;
- Fingernail polish remover;
- Paint Thinner;
- Energy Boosters,
- Red Devil Lye / Drano / Liquid Fire or other drain cleaner;
- Batteries;
- Table salt, rock salt, Epsom salts;

- Denatured alcohol;
- Vehicle starter fluid or spray – may be stolen from a farm and is often transported in a propane gas cylinder or a beer cooler;
- Road flares or match heads;
- Iodine crystals / Water binder obtained from farm supply store;
- Liquid Heat - from an auto supply store;
- Camp Stove Fuel / Coleman Fuel.

Equipment that may be used in methamphetamine production includes:

- Glass jars or mixing bowls;
- Propane tanks (as used for barbecue grills) to carry anhydrous ammonia;
- Plastic coolers to carry anhydrous ammonia;
- Large amount of coffee filters to strain liquids;
- Plastic tubing or hoses;
- A hot plate, camp stove or electric skillet for a heat source;
- A turkey baster to remove liquid from the top of a jar.

In the majority of situations in which methamphetamine is being manufactured, it is also being used by those involved in its production.

Common Chemicals

Chemical Description Hazards

- Acetic Anhydride - clear liquid - vinegar odor - vapors irritate eyes, nose and throat
- Acetone - clear liquid with sweet odor vapors irritate eyes and nose in high concentrations
- Bromobenzine - clear liquid, aromatic odor linked to leukemia
- Chloroform - clear liquid toxic to liver and kidneys - suspected carcinogen
- Cyclohexane - light yellow liquid with peppermint or acetone smell - mucous membrane irritant
- Benzaldahyde - almond and cherry smell - mild skin and respiratory irritant
- Ephedrine - white crystalline substance - no major hazards
- Ether - clear liquid DO NOT OPEN

- Glacial Acetic Acid - clear liquid, solid at temperatures below 45 degrees Fahrenheit - skin irritant
- Hydriodic Acid - clear liquid may turn brown when exposed to air - VERY DANGEROUS - severe respiratory irritant
- Hydrochloric Acid - clear liquid - will burn skin
- Lead Acetate - white powder - heavy vinegar odor - will absorb through skin and destroy nerve synapses
- Mercuric Chloride - white powder - deadly poison
- Methylamine - clear liquid, ammonia odor - severe respiratory irritant - will burn skin on contact
- Phenylacetic Acid - white crystals - urine odor - skin irritant

Chemical Description Hazards

- Phenyl 2 Propanone - clear liquid - turns amber when exposed to air – unknown risk - assume the worst possible
- Piperidine - yellow liquid with soapy feel - strong ammonia odor - strong central nervous system depressant
- Sodium Cyanide - chunky white crystal - bitter almond smell - will form hydrogen cyanide gas if mixed with acid
- Sodium Hydroxide Powder - pellets, or white lumps, may also be a liquid – corrosive to all tissues
- Sodium Metal - shiny silver - ignites when exposed to water
- Thionyl Chloride - clear, yellow or red liquid with pungent, choking odor - severely irritating to eyes, nose, and throat
- Thorium Nitrate - white powder - alpha radiation emitter

NOTE*:* It is recommended that each unit have annual training from the National Guard or other entity that provides free training about methamphetamine.

Contagious Diseases

While anyone can be exposed to contagious diseases in the normal course of daily activity, there are four conditions which may be present in the APS client population which are of specific concern to staff. These are:

- AIDS (acquired immune deficiency syndrome);
- Hepatitis;
- Tuberculosis (TB);
- Clostridium Difficile Infectious Diarrhea (C-DIF).

All of these infections are serious and can be life-threatening, even with proper diagnosis and treatment. All of the following information was obtained from the National Centers for Disease Control and Prevention (CDC). AIDS and hepatitis are caused by viruses. Tuberculosis is caused by a bacterium. Of the three illnesses, AIDS tends to be the most feared because it is the newest to be recognized, and effective treatment is not as well developed. However, it is not the most contagious nor the most commonly contracted. Any staff member who believes that they have been exposed to any infectious disease, while in the performance of job responsibilities, will need to file an Employee Safety Incident Report and may file for Workman's Compensation.

AIDS

The human immunodeficiency virus (HIV) is the agent which causes acquired immunodeficiency syndrome (AIDS). The virus is transmitted through bodily fluids, primarily blood, semen, vaginal fluid and breast milk. The virus has been found in very low quantities in saliva and tears. It has not been recovered from the sweat of any HIV infected persons.

Modes of Infection

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes with an infected person, through blood transfusion with blood not adequately screened. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding. Infection also occurs from getting accidentally stuck with a needle containing infected blood or from contact between a source of infected blood and an open cut or mucous membranes such as the eyes or inside of the nose. All of the evidence proves false that HIV can be transmitted through air, water, insects or casual contact with surfaces or objects touched or handled by an infected person.

HEPATITIS

Hepatitis is a viral infection that damages the liver. "Viral hepatitis" refers to several diseases caused by viruses that affect the liver. However the mode of infection by these viruses differs, as do the prevention measures and response to infection.

Hepatitis A

Modes of Infection

Hepatitis A is the disorder associated with unsanitary preparation of food or drink. Hepatitis A virus (HAV) is contracted by eating or drinking a substance that has been contaminated by the virus, or by hand to mouth contact. It is passed through the gastrointestinal tract. Contamination with feces from an infected person is the typical avenue of infection. Household or sexual contact, day care attendance or employment, and recent international travel are major risk factors. Infected food handlers and those who have used contaminated needles are also sources of contamination of food or drink. The infection can make you very ill for three to four weeks and usually resolves itself within 6 months. It does not develop into a chronic disease and It is very rarely fatal. Symptoms are fatigue, jaundice, fever and headache.

Hepatitis B and C

Modes of Infection

Although they are caused by different viruses, hepatitis B virus (HBV) and hepatitis C virus (HCV) are similar in that:

- They are both spread by exchange of body fluids or introduction of infected blood through transfusion, being stuck with or using instruments that are contaminated with blood from an infected person, etc.
- It is possible for the viruses to be transmitted at delivery from an infected mother to her baby.
- The diseases are chronic and can cause serious liver damage if untreated.

Hepatitis C is the most common blood-borne illness in the United States. A common avenue for infection is tattooing and body piercing with non-sterile instruments and conditions.

A significant difference between HBV and HCV is that there is a vaccine against HBV. At this time there is no vaccine available to prevent hepatitis C.

Tuberculosis

Tuberculosis (TB) is a disease caused by bacteria that usually attack the lungs. TB is spread through the air when an infected person sneezes or coughs. Exposure to the bacteria does not necessarily mean that a person will develop the disease or be infectious to others. In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria and stop it from

growing. The bacteria become inactive, but they remain alive in the body and can become active later, particularly if the person later develops a condition that weakens the immune system.

People with inactive TB infection:

- Have no symptoms, don't feel sick;
- Cannot spread TB to others;
- Usually have a positive skin test reaction;
- Can develop active TB disease at a later time if they do not receive preventive treatment.

Symptoms of active TB typically include:

- A bad cough that lasts longer than 2 weeks;
- Pain in the chest;
- Coughing up blood or sputum;
- Weakness or fatigue;
- Weight loss;
- No appetite;
- Chills / fever;
- Night sweats.

These symptoms can be associated with a number of conditions. The only way to determine whether you have tuberculosis infection is by diagnostic testing. This usually begins with a TB skin test. A positive skin test reaction does not necessarily mean that there is a current TB infection; however, it does indicate a need to discuss with the physician whether follow-up diagnostic tests are needed such as chest x-ray and/or sputum culture to determine whether there is need for treatment. The treatment protocol will involve taking antibiotics that are specific for TB bacteria, usually for at least 6 months. A person who is infectious will need to be in some sort of quarantine until treatment has rendered the disease noninfectious, which may take a few weeks. With TB, it is critical to continue taking all medications as prescribed to prevent resistant bacteria from surviving.

Clostridium Difficile Infectious Diarrhea (C-DIF)

C. DIF is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis, or sepsis, but rarely death. C.DIF is generally treated for 10 days with antibiotics prescribed by your healthcare provider. The drugs are effective and appear to have few side-effects.

The symptoms of C.D IF include:

- watery diarrhea (at least three bowel movements per day for two or more days),
- fever,
- loss of appetite,
- nausea,
- abdominal pain / tenderness.

Modes of Infection

People in good health usually don't get C.DIF. The elderly and people who have other illnesses or conditions requiring prolonged use of antibiotics are at greater risk of acquiring this disease. The bacteria are found in the feces. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to other patients or contaminate surfaces through hand contact.

Ordering Protective Supplies

For staff concerned about contamination from communicable disease, hazardous environment, etc., protective coverings may be ordered. None of these items can be obtained immediately upon request, so they should be ordered to be available promptly when needed.

To request an order of protective supplies, a request must be submitted to Office Services via the APS Program Director. It is important to specify the number of items that are being requested.

Following are some items that staff may request as needed to provide protection from communicable disease or biohazards such as meth sites:

- Face masks,
- Disposable protective shoe coverings,
- Disposable protective clothing coverings,
- Disposable protective coverings for car seats,
- Disposable gloves,
- Hand sanitizers,
- Lice spray,
- Bug spray.

Appendix K
SPECIAL CASE REVIEW PRACTICE GUIDE

Special Case Review Teams will review case situations meeting the criteria listed in the Special Case Review Policy. Cases may also be identified by the Department's management, outside professionals, political leaders, or may be cases in which the media have voiced serious concerns about service delivery involving APS. However, to prevent the team from becoming the primary means for handling routine complaints or overreacting to outside pressures, the Program Supervisor must approve the convening of a team**.**

Guidelines and Procedures

The Program Supervisor will determine, based on reviewing the case file, if a Special Case Review is necessary. The Program Supervisor, prior to making a decision, may request additional information. If it is determined that a Special Case Review is appropriate, the team will convene within 30 calendar days of the Program Supervisor's decision that the case warrants review.

Roles and Responsibilities

Program Supervisor

The Program Supervisor will be responsible for the following:

- Making arrangements for the team to meet, which would include date, time and location
- Confirming who will be in attendance
- Sending a duplicate case file to each participant at least two weeks prior to the review
- Facilitating the Special Team Review
- Composing a written report following the Special Team Review and notify the APS Director the report is complete

APS Counselor

The Counselor will present the case to the team, giving detailed information about the case from the time the referral was received. The Counselor should come prepared to provide any additional information that would be pertinent to the case and helpful for the team to better understand the case.

APS Field Supervisor

The APS Field Supervisor should come prepared to provide any additional information about the case to the team and assist the Counselor with the presentation.

Participation of Members

All team members will have an opportunity to discuss the case during the review and ask pertinent questions. All participants will participate in the recommendation process.

The counselor and Field Supervisor responsible for the case, as well as the other participants, will remain in the review during the recommendation process.

Special Case Review Summary Report

- Complete the form in the automated system

Appendix L
MULTI-DISCIPLINARY TEAM PRACTICE GUIDE

The first Multi-Disciplinary Team (M-Team) was established in 1983. The function of the team is to provide guidance and support for staff who are dealing with increasingly complex case situations involving adults referred for Adult Protective Services. In order to adequately protect those adults who suffer from diverse and complex risks, the cooperation of others working in conjunction with the Department is needed and beneficial.

Benefits

The team can prove to be valuable in the difficult role of safeguarding the client's right to self-determination while insuring protection. Benefits which can be gained from the team include:

- Assessing risks to clients;
- Providing input on appropriate methods and approaches the counselor can use in the delivery of services;
- Offering suggestions for possible alternatives and solutions;
- Consultation and support;
- Education of the community on Adult Protective Services issues;
- Casework intervention approaches and strategies;
- Development of case diagnosis and/or prognosis;
- Identification of service gaps / needs;
- Coordination and better utilization of existing resources;
- Development of resources to meet the identified service gaps / needs.

The M-Team is to be used on a case by case basis to provide consultation and support in difficult case situations. These case situations may include:

- Cases in which legal action is being considered and consultation from the team is needed;
- Case situations in which ideas / suggestions are needed on casework approaches or intervention strategies;
- Case situations where there is not a known or immediate resource to meet the client's needs and additional ideas and directions are needed;

- Cases in which closure is being considered, and the client is in danger and will not accept services, but appears to have the capacity to make the decision to reject services and thereby remain in danger;

- Cases in which the client's ability to make rational choices and decisions fluctuates and his / her decision making ability is at best borderline;

- Severe abuse, neglect or exploitation cases in which the client remains with or returns to the harmful situation and/or abuser;

- Borderline cases in which APS has been unable to clearly show that the client is in danger;

- Cases in which assistance is needed in making a case diagnosis and/or prognosis;

- Cases in which clients have fallen between the cracks (an example might be a client with a dual diagnosis of mental illness and mental retardation);

- Cases in which APS staff has been unable to make progress after repeated efforts have been made to provide services.

The M-Team approach is a way to gain greater perspective into the needs of and risks to Adult Protective Services clients and obtains more options and alternatives in meeting needs or reducing the risks.

Consideration must be given to the distance and amount of time staff would be required to travel to have access to a team. Teams should be available within a reasonable distance from each county.

The team is comprised of key professionals from the local community who have expertise and commitment to working with vulnerable adults. Involving key professionals within the community enhances the Department's ability to increase the community's awareness of the APS program, identify service gaps and needs, and develop or coordinate existing services.

The M-Team is an effective and efficient tool for staff working with Adult Protective Service cases; however, it requires staff with a commitment to the process to make it work.

Development and Use of M-Teams

Team members are sought from those individuals who have expertise or an interest in Adult Protective Services clients and issues. They should have a commitment to attend team meetings regularly.

A team member is responsible for carefully considering information presented, making recommendations, and advising the Department regarding alternatives which may be useful in a case. Team members may also be able to identify needed community resources.

Appointments and Terms of Team Members

To ensure the smooth operation or functioning of the team, it is beneficial to reappoint some of the team members at the end of their service. However, to facilitate the orientation process, it is also desirable to appoint several new members at this time. Resignations or non-participation of team members must be examined and handled from the standpoint of the teams' ability to function in light of these absences. Appointments may be made for one to two years based on the discretion of the supervisor.

Liability

As included in the appointment letter, team members will serve on the team in an advisory capacity. Department staff will make all final decisions on the cases which are reviewed. In accordance with T.C.A. §§ 8-44-101(3)(B) and 9-8-307(h), team members who are not DHS or other state agency employees will be registered with the State Board of Claims and will consequently be considered "state employees" for purposes of liability protection. This liability protection will extend within the scope of their duties as a team member except for willful, malicious or criminal acts or omissions or for acts or omissions done for personal gain.

T. C. A. § 8-42-101(3) (B) "State employee" also includes any person designated by a department or agency head as a participant in a volunteer program authorized by the department or agency head. "State employee" also includes community service agency volunteers designated by the commissioner of the Department of Health; provided, that designated volunteers who are medical professionals providing direct health care pursuant to title 37, chapter 5, part 3 shall be considered state employees solely for the category of "professional malpractice" pursuant to § 9-8-307**. Volunteers shall not be eligible for workers' compensation benefits from the state. It is the duty of each agency and department to register with the board of claims the names of all persons participating in a volunteer program authorized by such department or agency head. If an agency or department head fails to register the name of a volunteer with the board of claims, any amounts paid by the state pursuant to this chapter or title 9, chapter 8 as a result of the volunteer's actions shall be funded through the agency's or department's budget.** The commissioner of finance and administration is authorized to promulgate rules and regulations to determine who is qualified to be designated as a volunteer. Such rules and regulations may set forth the criteria for qualification of participants in volunteer programs. All such rules and regulations

omulgated shall be pr in accordance wit h the provisions of the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5.

The second page of the Volunteer Enrollment Form, HS-1262, is completed by each team member and, thereafter, registered with the Board of Claims on a yearly basis. This form is self-explanatory. In the section under Committees on the line by Other, write in Adult Protective Services Multidisciplinary Case Consultation Team. To be registered with the Board of Claims, the section of form below the perforated line, Registration of Volunteers, should be sent to Volunteer Registration c/o DHS Department of Human Resources, Citizens Plaza, 3rd Floor, 400 Deaderick Street, Nashville, TN 37243.

Confidentiality

A sample **Confidentiality Agreement** is included in the Forms Section. Each team member must sign the form, agreeing to maintain the confidentiality of the information shared with them as members of the Case Consultation Team. Team members have access to confidential, identifying, and personal information. The information discussed during the team meeting is not to be shared with anyone outside the Department and the team. The members of the team should be cautioned with regard to the criminal penalties imposed (Class B misdemeanor) for disclosing information outside of the parameters of the APS program.

Orientation

It is important to spend some time at the beginning of a new appointment to orient the individual regarding the parameters of APS. When conducting the orientation, it is critical that the new appointee be informed of the APS law, policy around APS investigation and provision of on-going services, the client's right to self determination, legal intervention avenues, etc. Educating the new appointee prior to actually attending a team meeting will provide a knowledge base regarding APS for that individual and will lessen the time spent answering questions about APS.

TEAM MEETINGS

Frequency and Length

Meetings may be scheduled on a monthly basis, or may be called in emergency situations. The length of the meetings will vary depending upon the number and/or complexity of the cases discussed. A recommended length of time is one to two hours.

Time and Location

Input from team members should be sought when setting the time (morning or afternoon) and also the possible location (if there is a need to meet outside of the DHS office). Members should be asked, when recruited, about availability and the location of the meetings (when appropriate). Be flexible when setting a meeting time. For instance, some team members may have a preference to meet at 8:00 am because they have busy schedules, and it is easier to set aside an hour or so early in the morning before reporting to their work assignments. Others may need to check-in at their work places before attending a team meeting. Currently most of the teams meet in the DHS offices; however, if holding the meeting elsewhere will enable the team to have participation that would not otherwise be available, it is important to be flexible. For example, if it is not convenient for the physician to come to the DHS office, determine if there is a more convenient meeting place if this will facilitate participation by all members.

Attendees

Only the individuals necessary for team functioning should be present at team meetings: team members, and DHS staff (counselor, supervisor / coordinator). For in-service training purposes, new DHS staff may attend team meetings as observers. On occasion a team member may ask to bring an individual who may be a future / potential team member. The coordinator will decide on the appropriateness of the individual's attendance. Occasionally professionals involved with the client who have pertinent information to share may wish to make a presentation to the team. The coordinator should arrange for and allot time for the professional (who is not a member of the team) to make his / her presentation. The professional should not be present during the general discussion of the case because of the need to maintain confidentiality. The counselor can share the team's recommendation with the specific professional, as appropriate.

Emergency Meetings

Provisions for calling emergency / special meetings to handle special or emergency circumstances which may develop should be made with the team members.

Tennessee Department of Human Services

ADULT PROTECTIVE SERVICES LAW

T. C. A. § 71

(Section added 7/11)

T. C. A. § 71-6-101

§ 71-6-101. Short title

Currentness

(a) This part may be cited as the "Tennessee Adult Protection Act."

(b)(1) The purpose of this part is to protect adults coming within the provisions of the part from abuse, neglect or exploitation by requiring reporting of suspected cases by any person having cause to believe that such cases exist. It is intended that, as a result of such reports, the protective services of the state shall prevent further abuse, neglect or exploitation within the limitations set out in this part.

(2) It is recognized that adequate protection of adults will require the cooperation of many agencies and service providers in conjunction with the department of human services due to the often complex nature of the risks to this adult group, and that services to meet the needs of this group will not always be available in each community. However, it is desirable that the following services, as well as other services needed to meet the intent of this part, be available: medical care, mental health and developmental disabilities services, including in-home assessments and evaluations; in-home services including homemaker, home-health, chore, meals; emergency services including shelter; financial assistance; legal services; transportation; counseling; foster care; day care; respite care; and other services as needed to carry out the intent of this part.

Credits

1978 Pub.Acts, c. 899, § 1; 1986 Pub.Acts, c. 630, § 1.

Formerly § 14-2601; § 14-25-101.

Notes of Decisions (3)

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-102

§ 71-6-102. Definitions

Currentness

As used in this part, unless the context otherwise requires:

(1) "Abuse or neglect" means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare. Nothing in this part shall be construed to mean a person is abused or neglected or in need of protective services for the sole reason that the person relies on or is being furnished treatment by spiritual means through prayer alone in accordance with a recognized religious method of healing in lieu of medical treatment; further, nothing in this part shall be construed to require or authorize the provision of medical care to any terminally ill person if such person has executed an unrevoked living will in accordance with the provisions of the Tennessee Right to Natural Death Act, compiled in title 32, chapter 11, and if the provisions of such medical care would conflict with the terms of such living will;

(2) "Adult" means a person eighteen (18) years of age or older who because of mental or physical dysfunctioning or advanced age is unable to manage such person's own resources, carry out the activities of daily living, or protect such person from neglect, hazardous or abusive situations without assistance from others and who has no available, willing, and responsibly able person for assistance and who may be in need of protective services; provided, however, that a person eighteen (18) years of age or older who is mentally impaired but still competent shall be deemed to be a person with mental dysfunction for the purposes of this chapter;

(3) "Advanced age" means sixty (60) years of age or older;

(4) "Capacity to consent" means the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts. A decision itself to refuse services cannot be the sole evidence for finding the person lacks capacity to consent;

(5)(A) "Caretaker" means an individual or institution who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult person voluntarily, or by contract, or agreement;

(B) A financial institution is not a caretaker of funds or other assets unless such financial institution has entered into an agreement to act as a trustee of such property or has been appointed by a court of competent jurisdiction to act as a trustee with regard to the property of the adult;

(6) "Commissioner" means the commissioner of human services;

(7) "Department" means the department of human services;

(8) "Exploitation" means the improper use by a caretaker of funds that have been paid by a governmental agency to an adult or to the caretaker for the use or care of the adult;

(9) “Imminent danger” means conditions calculated to and capable of producing within a relatively short period of time a reasonable probability of resultant irreparable physical or mental harm or the cessation of life, or both, if such conditions are not removed or alleviated. However, the department is not required to assume responsibility for a person in imminent danger pursuant to this chapter except when, in the department’s determination, sufficient resources exist for the implementation of this part;

(10) “Investigation” includes, but is not limited to, a personal interview with the individual reported to be abused, neglected, or exploited. When abuse or neglect is allegedly the cause of death, a coroner’s or doctor’s report shall be examined as part of the investigation;

(11) “Protective services” means services undertaken by the department with or on behalf of an adult in need of protective services who is being abused, neglected, or exploited. These services may include, but are not limited to, conducting investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether or not the situation and condition of the adult in need of protective services warrants further action; social services aimed at preventing and remedying abuse, neglect, and exploitation; services directed toward seeking legal determination of whether the adult in need of protective services has been abused, neglected or exploited and procurement of suitable care in or out of the adult’s home;

(12) “Relative” means spouse; child, including stepchild, adopted child or foster child; parents: including stepparents, adoptive parents or foster parents; siblings of the whole or half-blood; step-siblings, grandparents, grandchildren, of any degree, and aunts, uncles, nieces and nephews; and

(13) “Sexual abuse” occurs when an adult, as defined in this chapter, is forced, tricked, threatened or otherwise coerced by a person into sexual activity, involuntary exposure to sexually explicit material or language, or sexual contact against such adult’s will. Sexual abuse also occurs when an “adult,” as defined in this chapter, is unable to give consent to such sexual activities or contact and is engaged in such activities or contact with another person.

Credits

1978 Pub.Acts, c. 899, § 1; 1980 Pub.Acts, c. 513, § 2; 1986 Pub.Acts, c. 630, §§ 2, 3; 1995 Pub.Acts, c. 486, §§ 1, 2, 9, 17, eff. June 12, 1995; 1996 Pub.Acts, c. 1029, § 1, eff. May 15, 1996; 2004 Pub.Acts, c. 780, § 4, eff. July 1, 2004; 2009 Pub.Acts, c. 337, §§ 1, 2, eff. July 1, 2009; 2010 Pub.Acts, c. 898, § 1, eff. May 10, 2010.

Formerly § 14-2602; § 14-25-102.

Notes of Decisions (3)

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-103

§ 71-6-103. Rules and regulations; reports; investigations; providing protection

Currentness

(a) The commissioner has the discretion to adopt such rules, regulations, procedures, guidelines, or any other expressions of policy necessary to effect the purpose of this part insofar as such action is reasonably calculated to serve the public interest.

(b)(1) Any person, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this part. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death. However, unless the report indicates that there are other adults in the same or similar situation and that an investigation and provision of protective services are necessary to prevent their possible abuse, neglect or exploitation, it shall not be necessary for the department to make an investigation of the circumstances surrounding the death; provided, that the appropriate law-enforcement agency is notified.

(2) If a hospital, clinic, school, or any other organization or agency responsible for the care of adults has a specific procedure, approved by the director of adult protective services for the department, or the director's designee, for the protection of adults who are victims of abuse, neglect, or exploitation, any member of its staff whose duty to report under the provisions of this part arises from the performance of the staff member's services as a member of the staff of the organization may, at the staff member's option, fulfill that duty by reporting instead to the person in charge of the organization or the organization head's designee who shall make the report in accordance with the provisions of this chapter.

(c) An oral or written report shall be made immediately to the department upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult. Any person making such a report shall provide the following information, if known: the name and address of the adult, or of any other person responsible for the adult's care; the age of the adult; the nature and extent of the abuse, neglect, or exploitation, including any evidence of previous abuse, neglect, or exploitation; the identity of the perpetrator, if known; the identity of the complainant, if possible; and any other information that the person believes might be helpful in establishing the cause of abuse, neglect, or exploitation. Each report of known or suspected abuse of an adult involving a sexual offense that is a violation of §§ 39-13-501--39-13-506 that occurs in a facility licensed by the department of mental health as defined in § 33-5-402, or any hospital shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.

(d) Upon receipt of the report, the department shall take the following action as soon as practical:

(1) Notify the appropriate law enforcement agency in all cases in which the report involves abuse, neglect, or exploitation of the adult by another person or persons;

(2) Notify the appropriate licensing authority if the report concerns an adult who is a resident of, or at the time of any alleged harm is receiving services from, a facility that is required by law to be licensed or the person alleged to have caused or permitted the harm is licensed under title 63. The commissioner of health, upon becoming aware through personal knowledge, receipt of a report or otherwise, of confirmed exploitation, abuse, or neglect of a nursing home resident, shall report such instances to the Tennessee bureau of investigation for a determination by the bureau as to whether the circumstances reported constitute abuse of the medicaid program or other criminal violation;

(3) Initiate an investigation of the complaint;

(4) Make a written report of the initial findings together with a recommendation for further action, if indicated; and

(5) After completing the evaluation, the department shall notify the person making the report of its determination.

(e) Any representative of the department may enter any health facility or health service licensed by the state at any reasonable time to carry out its responsibilities under this part.

(f) Any representative of the department may, with consent of the adult or caretaker, enter any private premises where any adult alleged to be abused, neglected, or exploited is found in order to investigate the need for protective services for the purpose of carrying out the provisions of this part. If the adult or caretaker does not consent to the investigation, a search warrant may issue upon a showing of probable cause that an adult is being abused, neglected, or exploited, to enable a representative of the department to proceed with the investigation.

(g) If a determination has been made that protective services are necessary when indicated by the investigation, the department shall provide such services within budgetary limitations, except in such cases where an adult chooses to refuse such services.

(h) In the event the adult elects to accept the protective services to be provided by the department, the caretaker shall not interfere with the department when rendering such services.

(i) If the adult does not consent to the receipt of protective services, or if the adult withdraws consent, the services shall be terminated, unless the department determines that the adult lacks capacity to consent, in which case it may seek court authorization to provide protective services.

(j)(1) Any representative of the department actively involved in the conduct of an abuse, neglect, or exploitation investigation under this part shall be allowed access to the mental and physical health records of the adult that are in the possession of any individual, hospital, or other facility if necessary to complete the investigation mandated by this chapter.

(2) To complete the investigation required by this part, any authorized representative of the department actively involved in the conduct of an investigation pursuant to this part shall be allowed access to any law enforcement records or personnel records, not otherwise specifically protected by statute, of any person who is:

(A) A caretaker of the adult, or

(B) The alleged perpetrator of abuse, neglect or exploitation of the adult, who is the subject of the investigation.

(3)(A) If refused any information pursuant to subdivisions (j)(1) and (2), any information from any records necessary for conducting investigations pursuant to this part may be obtained upon motion by the department to the circuit, chancery or general sessions court of the county where such records are located, or in the court in which any proceeding concerning the adult may have been initiated or in the court in the county in which the investigation is being conducted.

(B) The order on the department's motion may be entered ex parte upon a showing by the department of an immediate

need for such information.

(C) The court may enter such orders as may be necessary to ensure that the information sought is maintained pending any hearing on the motion, and to protect the information obtained from further disclosure if the information is made available to the department pursuant to the court's order.

(4)(A) The department may be allowed access to financial records that are contained in any financial institution, as defined by § 45-10-102(3) regarding:

(i) The person who is the subject of the investigation;

(ii) Any caretaker of such person; and

(iii) Any alleged perpetrator of abuse, neglect or exploitation of such person;

(B) By the issuance of an administrative subpoena in the name of the commissioner or an authorized representative of the commissioner that is:

(i) Directed to the financial institution, and

(ii) Complies with the provisions of §§ 45-10-106 and 45-10-107; or

(C) By application, as otherwise required pursuant to § 45-10-117, to the circuit or chancery court in the county in which the financial institution is located, or in the court in which any proceeding concerning the adult may have been initiated or in which the investigation is being conducted, for the issuance of a judicial subpoena that complies with the requirements of § 45-10-107; provided that the department shall not be required to post a bond pursuant to § 45-10-107(a)(4).

(D) Nothing in this subdivision (j)(4) shall be construed to supersede the provision of financial records pursuant to the permissible acts allowed pursuant to § 45-10-103.

(5) Any records received by the department, the confidentiality of which is protected by any other statute or regulation, shall be maintained as confidential pursuant to the provisions of such statutes or regulations, except for such use as may be necessary in the conduct of any proceedings pursuant to its authority pursuant to this part or title 33 or 34.

(k)(1) If, as a result of its investigation, the department determines that an adult who is a resident or patient of a facility owned or operated by an administrative department of the state is in need of protective services, and the facility is unable or unwilling to take action to protect the resident or patient, the department shall make a report of its investigation, along with any recommendations for needed services to the commissioner of the department having responsibility for the facility. It shall then be the responsibility of the commissioner for that department and not the department of human services to take such steps as may be necessary to protect the adult from abuse, neglect, or exploitation and, in such cases, the affected administrative department of the state shall have standing to petition the court.

(2)(A) Notwithstanding subdivision (k)(1) or any other provision of this part to the contrary, the department of human

services shall not be required to investigate and the department of mental health or the department of intellectual and developmental disabilities, or their successor agencies, shall not be required to report to the department of human services any allegations of abuse, neglect or exploitation involving any person that arise from conduct occurring in any institutions operated directly by either the department of mental health or the department of intellectual and developmental disabilities.

(B) Allegations of abuse, neglect or exploitation of individuals occurring in the circumstances described in subdivision (k)(2)(A) shall be investigated, respectively, by investigators of the department of mental health and the department of intellectual and developmental disabilities, or their successor agencies, who have been assigned to investigate the allegations.

(*l*) In the event the department, in the course of its investigation, is unable to determine to its satisfaction that sufficient information is available to determine whether an adult is in imminent danger or lacks the capacity to consent to protective services, an order may be issued, upon a showing of probable cause that an adult lacks capacity to consent to protective services and is being abused, neglected, or exploited, to require the adult to be examined by a physician, a psychologist in consultation with a physician or a psychiatrist in order that such determination can be made. An order for examination may be issued ex parte upon affidavit or sworn testimony if the court finds that there is cause to believe that the adult may be in imminent danger and that delay for a hearing would be likely to substantially increase the adult's likelihood of irreparable physical or mental harm, or both, and/or the cessation of life.

Credits

1978 Pub.Acts, c. 899, § 1; 1980 Pub.Acts, c. 513, §§ 3 to 5, 8; 1986 Pub.Acts, c. 630, §§ 5 to 8; 1993 Pub.Acts, c. 439, § 3, eff. July 1, 1993; 1995 Pub.Acts, c. 486, §§ 2, 14, eff. June 12, 1995; 1999 Pub.Acts, c. 247, § 2, eff. May 27, 1999; 2000 Pub.Acts, c. 947, §§ 6, 8M, eff. June 23, 2000; 2001 Pub.Acts, c. 204, §§ 1, 2, eff. May 10, 2001; 2003 Pub.Acts, c. 169, § 7, eff. July 1, 2003; 2009 Pub.Acts, c. 212, §§ 1, 2, eff. May 13, 2009; 2010 Pub.Acts, c. 1100, §§ 141, 142, eff. Jan. 15, 2011.

Formerly § 14-2603; § 14-25-103.

Notes of Decisions (1)

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-104

§ 71-6-104. Injunctive relief

Currentness

(a) Any court with jurisdiction under this part may upon proper application by the department issue a temporary restraining order or other injunctive relief to prohibit any violation of this part, regardless of the existence of any other remedy at law.

(b) The court may enjoin from providing care for any person, on a temporary or permanent basis, any employee or volunteer, who the court finds has engaged in the abuse, neglect or exploitation of an adult as defined in this part, in any situation involving the care of such adult by such employee or volunteer, whether such actions occurred in an institutional setting, in any type of group home or foster care arrangement serving adults, and regardless of whether such person, facility or arrangement serving adults is licensed to provide care for adults.

Credits

1978 Pub.Acts, c. 899, § 1; 1986 Pub.Acts, c. 630, § 18; 1995 Pub.Acts, c. 486, § 8, eff. June 12, 1995.

Formerly § 14-2604; § 14-25-104.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-105

§ 71-6-105. Reports and investigations; privileges and immunities; retaliation; damages

Currentness

Any person making any report or investigation pursuant to this part, including representatives of the department in the reasonable performance of their duties and within the scope of their authority, shall be presumed to be acting in good faith and shall thereby be immune from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or investigation. Any person making a report under the provisions of this part shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes a detrimental change in the employment status of the reporting party by reason of the report.

Credits

1978 Pub.Acts, c. 899, § 1; 1980 Pub.Acts, c. 513, § 6.

Formerly § 14-2605; § 14-25-105.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-106

§ 71-6-106. Confidential or privileged information; exceptions

Currentness

Notwithstanding the existence of the privilege for confidential communications between husband and wife, the chancellor at the hearing may compel testimony if, in the chancellor's opinion, disclosure is necessary in the interest of the adult.

Credits

1978 Pub.Acts, c. 899, § 1.

Formerly § 14-2606; § 14-25-106.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-107

§ 71-6-107. Protective services; proceedings; capacity to consent; court costs

Currentness

(a)(1)(A) If the department determines that an adult who is in need of protective services is in imminent danger if that adult does not receive protective services and lacks capacity to consent to protective services, then the department may file a complaint with the court for an order authorizing the provision of protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life. The judge or chancellor shall hear the complaint ahead of any other business then pending in court or in chambers. This order may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf. The complaint must allege specific facts sufficient to show that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services. Prior to filing a complaint with the court for an order authorizing removal of an adult from that adult's chosen place of residence, the department shall make reasonable efforts to exhaust all practical alternatives to the removal of such adult from such place of residence.

(B) In situations where the department must present a petition for emergency removal of an adult in imminent danger and a chancellor or circuit judge is unavailable, the department may present petitions to judicial officers with general sessions jurisdiction. Further proceedings shall be conducted in chancery or circuit court.

(C) For the purposes of this section, "sexual abuse," as defined in this chapter, shall provide grounds for the department to obtain custody of an adult who lacks capacity to consent when such abuse relates to sexual activity or contact.

(2) The judge or chancellor or the general sessions court judge, prior to entering the order, must find that the adult is in imminent danger if the adult does not receive protective services and lacks capacity to consent to protective services.

(3) Within seven (7) days of entering an order pursuant to this section, or for good cause shown, then up to fifteen (15) days, the court shall hold a hearing on the merits. If such a hearing is not held within such time, the order authorizing the provision of protective services shall be dissolved.

(4)(A) The adult alleged to be in need of protective services and any person to whom the adult is lawfully married, if known and reasonably available, must be served with a copy of the complaint at least forty-eight (48) hours prior to the hearing, unless for good cause shown, a shorter time is allowed by the court. The adult and the adult's spouse have a right to be present and represented by counsel at the hearing. Failure to serve a copy of the complaint on a lawful spouse of the adult, if the spouse is not known or is not reasonably available as determined by the court, shall not prevent the provision of protective services, as ordered by the court, that may be necessary to prevent the adult from suffering imminent harm.

(B) If the adult alleged to be in need of protective services is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel for the adult alleged to be in need of protective services.

(C) If the adult alleged to be in need of protective services is indigent, court costs and the cost of representation of the adult shall be borne by the state; otherwise, the costs shall be borne by the adult. The state shall not be liable for the cost of

counsel or court costs for the spouse of the adult; provided, however, that if the court finds that the department or an agency acting under subdivision (a)(7) has, without good cause, failed to serve a copy of the complaint on the lawful spouse of the adult, the court may assess attorneys fees for the spouse of the adult and court costs to the department or agency acting under subdivision (a)(7) not to exceed a total of two thousand dollars ($2,000); provided further, however, that the court may exceed the two thousand dollar ($2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars ($2,000) and that the interests of justice require that the limit be exceeded in the particular case.

(D) If a court determines that appointment of a guardian ad litem is necessary, and if the adult is indigent, the cost for the guardian ad litem shall be borne by the state; otherwise the costs shall be borne by the adult.

(5)(A) Protective services necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life authorized by order pursuant to this section may include, but are not limited to, taking the adult into physical custody in the home, a medical or nursing care facility, or, if available, an alternative living arrangement exclusive of a developmental center operated by the department of intellectual and developmental disabilities; provided, that the court finds that such custody is for the purpose of medical examination and treatment necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life or protection from abuse or neglect necessary to prevent imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life, and that the court specifically authorizes such custody in its order. In determining what specific custodial authority to grant under this section, the court shall consider whether the imminent danger of irreparable physical or mental harm, or both, and/or the cessation of life is relatively mild or severe and authorize such custody as is appropriate under the circumstances. The department shall review the decree at least annually to determine whether the prerequisites for custody still exist.

(B) Within a reasonable period of time after an adult is taken into physical custody and placed other than in a medical or nursing care facility, the department shall cause an appropriate examination to be made of the adult to determine the cause or causes resulting in the adult's lack of capacity to consent, if such determination had not been made at the time of the final hearing.

(6)(A) In the event that the adult has sufficient resources to defray the costs of a medical or nursing care facility, or an appropriate alternative living arrangement, as decreed by the court pursuant to this subsection (a), and that without such resources the adult would be unable to enter such facility or alternative living arrangement, then the court may appoint a temporary guardian for such period as necessary to secure and disburse the adult's resources for that purpose, but for no longer than six (6) months from the entry of the order authorizing provision of protective services. However, the court in its discretion may extend such period for a period no longer than an additional six (6) months. The guardian appointed pursuant hereto shall file an accounting with the court as to the resources used.

(B) The court in its order may authorize the temporary guardian to exercise a limited power of attorney over any accounts the adult has in a bank, credit union, or other financial institution. The temporary guardian so designated shall deliver a copy of the order of the court to the financial institution prior to taking any action with regard to the accounts. The limited power of attorney shall authorize the temporary guardian to withdraw money from or freeze or unfreeze the account.

(C) Concurrent with the order of the court appointing a temporary guardian, the court shall issue a subpoena directed to the financial institution in compliance with the Financial Records Privacy Act, compiled in title 45, chapter 10, requesting the names of any co-owner or additional authorized signatories on the accounts, unless the temporary guardian has actual knowledge of any co-owners or additional authorized signatories. Upon receipt of the response to the subpoena, or upon actual knowledge of the co-owners or additional authorized signatories, the temporary guardian shall send a copy of the order to any person who is a co-owner of or authorized signatory on the deposit account within ten (10) days of receiving the names of the co-owners or signatories. Nothing in this subdivision (a)(6)(C) shall preclude the temporary guardian from making immediate expenditures from the accounts of the adult necessary to provide protective services for the adult in imminent danger, as defined in this part, pending the response by the co-owners or other signatories to the accounts.

(D) If the court finds that the temporary guardian has, without good cause, failed to provide a copy of the order under this subdivision (a)(6) to the co-owner or additional authorized signatory on the deposit account, the court may assess attorneys' fees for the benefit of the co-owner or additional authorized signatory or court costs associated with the failure of the department or the temporary guardian; provided, that the fees and court costs shall not exceed a total of two thousand dollars ($2,000); provided, further, however, that the court may exceed the two thousand dollar ($2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars ($2,000) and that the interests of justice require that the limit be exceeded in the particular case.

(7) If the department refuses to exercise the powers granted to it by subdivision (a)(1), any private non-profit agency representing disabled adults may proceed under subdivision (1), after giving notice to the department of intent to do so. If an order authorizing the provision of protective services results, the department's responsibilities are the same as they would have been if the department had sought the order. If the court finds that an order authorizing the provision of protected services is not warranted, any agency proceeding under this subdivision (a)(7) will be responsible for the cost of the court-appointed attorney representing the individual for whom protective services were sought as well as court costs.

(b)(1) If the department determines that an adult is in need of protective services and lacks capacity to consent to protective services, then the department may petition the judge or chancellor for a hearing. The complaint must allege specific facts sufficient to show that the adult is in need of protective services and lacks capacity to consent to protective services.

(2)(A) The adult alleged to be in need of protective services and any person to whom the adult is lawfully married, if known and reasonably available, must be served with a copy of the complaint at least ten (10) days prior to the hearing, unless for good cause shown, a shorter time is allowed by the court. The adult and the adult's spouse have a right to be present and represented by counsel at the hearing. Failure to serve a copy of the complaint on a lawful spouse of the adult, if the spouse is not known or is not reasonably available as determined by the court, shall not prevent the provision of protective services to the adult, as ordered by the court.

(B) If the adult alleged to be in need of protective services is indigent or, in the determination of the judge or chancellor, lacks capacity to waive the right to counsel, then the court shall appoint counsel for the adult alleged to be in need of protective services.

(C) If the adult alleged to be in need of protective services is indigent, court costs and the cost of representation of the adult shall be borne by the state; otherwise the costs shall be borne by the adult. The state shall not be liable for the costs of counsel or court costs for the spouse of the adult; provided, however, if the court finds that the department or an agency acting under subdivision (7) has, without good cause, failed to serve a copy of the complaint on the lawful spouse of the adult, the court may assess attorneys fees for the spouse of the adult and court costs to the department or agency acting under subdivision (7) not to exceed a total of two thousand dollars ($2,000); provided, however, that the court may exceed the two thousand dollar ($2,000) limit upon making a specific finding of fact that the failure of the department or an agency to serve the complaint resulted in financial hardship upon the spouse or adult in excess of two thousand dollars ($2,000) and that the interests of justice require that the limit be exceeded in the particular case.

(D) If a court determines that appointment of a guardian ad litem is necessary, and if the adult is indigent, the cost for the guardian ad litem shall be borne by the state; otherwise the costs shall be borne by the adult.

(3) If the judge or chancellor finds that the adult is in need of protective services and lacks capacity to consent to protective services, then the judge or chancellor may enter a decree authorizing the provision of protective services. This decree may include the designation of an individual or organization to be responsible for the personal welfare of the adult and for

consenting to protective services in the adult's behalf.

(c) An individual or organization appointed pursuant to subsection (a) or (b) to be responsible for the personal welfare of the adult and for consenting to protective services in the adult's behalf or to serve as temporary guardian shall have only specific authority as the court shall provide in its order. Such authority shall be limited to the authority to consent to specified protective services, including medical care if ordered, and if ordered pursuant to subsection (a), may arrange for, and consent to, appropriate custodial care and gain access to and disburse the adult's resources. If the adult is in need of a person to manage the adult's affairs or to have other responsibilities not addressed in this section, the procedures and requirements for appointment of a conservator pursuant to title 34, chapter 1 or 3, must be followed. Nothing in this section shall be construed as requiring the department to initiate proceedings for the appointment of a conservator or a temporary guardian or to accept such appointment if proceedings are instituted or to initiate proceedings under title 34, chapter 1 or 3.

Credits

1978 Pub.Acts, c. 899, § 1; 1980 Pub.Acts, c. 513, § 7; 1986 Pub.Acts, c. 630, §§ 9 to 14; 1986 Pub.Acts, c. 892, § 1; 1995 Pub.Acts, c. 486, §§ 2 to 5, 7, 10 to 13, 15, 19, eff. June 12, 1995; 1999 Pub.Acts, c. 247, § 3, eff. May 27, 1999; 2000 Pub.Acts, c. 947, § 6, eff. June 23, 2000; 2008 Pub.Acts, c. 887, §§ 1 to 3, eff. July 1, 2008; 2008 Pub.Acts, c. 1005, §§ 2, 3, eff. July 1, 2008; 2010 Pub.Acts, c. 1100, § 143, eff. Jan. 15, 2011.

Formerly § 14-2607; § 14-25-107.

Notes of Decisions (10)

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-108

§ 71-6-108. Incompetency; commitment; applicability

Currentness

No adult may be adjudicated incompetent or committed to a mental institution under this part.

Credits

1978 Pub.Acts, c. 899, § 1.

Formerly § 14-2608; § 14-25-108.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-109

§ 71-6-109. Protective services; payment

Currentness

If the department determines that the adult is financially capable of paying for the protective services received, according to standards to be set by the department, the adult shall reimburse the state for the cost of providing the protective services. If the department determines that the adult is not financially capable of paying for the protective services received, the state shall bear the cost of providing the protective services. Otherwise, the department may recover such cost from the adult in any court of competent jurisdiction.

Credits

1978 Pub.Acts, c. 899, § 1.

Formerly § 14-2609; § 14-25-109.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-110

§ 71-6-110. Reports; noncompliance; crimes and offenses

Currentness

Any person who knowingly fails to make a report required by this chapter commits a Class A misdemeanor.

Credits

1978 Pub.Acts, c. 899, § 1; 1986 Pub.Acts, c. 630, § 15; 1989 Pub.Acts, c. 591, § 111.

Formerly § 14-2610; § 14-25-110.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-111

§ 71-6-111. Legislative intent

Currentness

It is the legislative intent that the protective services set out in this part be provided and that the department have present authority to provide or to arrange for the provision of the same. However, the provision of the services is subject to budgetary limitations and the availability of funds appropriated for the general provision of protective services to all persons entitled to services.

Credits

1978 Pub.Acts, c. 899, § 1.

Formerly § 14-2611; § 14-25-111.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-112

§ 71-6-112. Funds

Currentness

The cost of the administration of this part and the provision of the services hereby authorized shall be limited to the amount of funds specifically appropriated for such purposes by the general assembly.

Credits

1978 Pub.Acts, c. 899, § 1.

Formerly § 14-2612; § 14-25-112.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-113

§ 71-6-113. Interdepartmental cooperation; specialized care or treatment; priorities and preferences

Currentness

(a) It is the legislative intent that the departments of mental health, intellectual and developmental disabilities, and health, or their successor agencies, shall assist the department of human services with providing the services required under this part.

(b) When the department of human services is unable to find a resource for any person in need of protective services who, because of mental or physical illness, mental retardation or developmental disabilities, is in need of specialized care or medical treatment, the departments of mental health, intellectual and developmental disabilities, and health, or their successor agencies, shall, based upon available resources, give priority to the person for appropriate placement or treatment if the person is eligible for placement.

Credits

1978 Pub.Acts, c. 899, § 2; 1986 Pub.Acts, c. 630, § 16; 2000 Pub.Acts, c. 947, § 6, eff. June 23, 2000; 2009 Pub.Acts, c. 212, § 3, eff. May 13, 2009; 2010 Pub.Acts, c. 1100, §§ 144, 145 eff. Jan. 15, 2011.

Formerly § 14-2613; § 14-25-113.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-114

§ 71-6-114. Jurisdiction; venue

Currentness

(a) The circuit, general sessions, and chancery courts have jurisdiction of proceedings arising under this part. Probate courts in counties having a population of not less than seven hundred seventy-five thousand (775,000) according to the 1980 federal census or any subsequent federal census shall have concurrent jurisdiction with the circuit and chancery courts.

(b) A proceeding under this part may be commenced in the county where the adult resides or is physically present.

Credits

1986 Pub.Acts, c. 630, § 4; 1995 Pub.Acts, c. 486, § 16, eff. June 12, 1995.

Formerly § 14-25-114.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-115

§ 71-6-115. Law enforcement officers; cooperation

Currentness

It is the legislative intent that law enforcement officials shall cooperate with the department of human services in providing protective services under this part. Further, when the department is unable to return an adult to physical custody who voluntarily leaves such custody, law enforcement officials shall assist in returning the adult to such physical custody and shall give priority in providing such assistance.

Credits

1986 Pub.Acts, c. 630, § 17.

Formerly § 14-25-115.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-116

§ 71-6-116. Appeal and review

Currentness

Either party to a proceeding under this part, or any interested person on behalf of the adult subject to such a proceeding, may file a motion for review of the decree of the court at any time.

Credits

1986 Pub.Acts, c. 630, § 17.

Formerly § 14-25-116.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-117

§ 71-6-117. Knowing abuse, neglect or exploitation; crimes and penalties

Currentness

(a) It is an offense for any person to knowingly, other than by accidental means, abuse, neglect or exploit any adult within the meaning of the provisions of this part.

(b) A violation of this section is a Class E felony.

Credits

1986 Pub.Acts, c. 630, § 17; 1989 Pub.Acts, c. 591, § 111; 2007 Pub.Acts, c. 416, § 1, eff. June 11, 2007.

Formerly § 14-25-117.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-118

§ 71-6-118. Confidential or privileged information; crimes and offenses

Currentness

(a) The identity of a person who reports abuse, neglect, or exploitation as required under this part is confidential and may not be revealed unless a court with jurisdiction under this part so orders for good cause shown.

(b) Except as otherwise provided in this part, it is unlawful for any person, except for purposes directly connected with the administration of this part, to disclose, receive, make use of, authorize or knowingly permit, participate, or acquiesce in the use of any list or the name of, or any information concerning, persons receiving services pursuant to this part, or any information concerning a report or investigation of a report of abuse, neglect, or exploitation under this part, directly or indirectly derived from the records, papers, files or communications of the department of human services or divisions thereof acquired in the course of the performance of official duties.

(c)(1) When necessary to protect adults in a health care facility licensed by any state agency, such information, reports, and investigations may be disclosed to any agency providing licensing or regulation for that facility; however, the information, reports, and investigations shall retain the protection of subsection (b) when disclosed to such agency and may not be disclosed to, or used by, any other person.

(2) Notwithstanding subsections (a) and (b), the department may report to law enforcement or public health authorities any information from its investigations or records regarding illness, disease or injuries obtained in the course of its investigation.

(d) A violation of any provision of this section is a Class B misdemeanor.

Credits

1986 Pub.Acts, c. 630, § 17; 1989 Pub.Acts, c. 591, § 112; 2008 Pub.Acts, c. 1005, §§ 4, 5, eff. July 1, 2008.

Formerly § 14-25-118.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-119

§ 71-6-119. Knowing physical abuse or gross neglect of an impaired adult

Currentness

(a) It is an offense to knowingly, other than by accidental means, physically abuse or grossly neglect an impaired adult if the abuse or neglect results in serious mental or physical harm.

(b) In order to prosecute and convict a person for a violation of this section, it is not necessary for the state to prove the adult sustained serious bodily injury as required by § 39-13-102, but only that the elements set out in subsection (a) occurred.

(c) A violation of this section is a Class C felony.

Credits

1995 Pub.Acts, c. 486, § 6, eff. June 12, 1995; 2007 Pub.Acts, c. 468, § 1, eff. July 1, 2007.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-120

§ 71-6-120. Action for abuse or neglect, sexual abuse or exploitation, or theft; right of recovery for elderly person or disabled adult

Currentness

(a) As used in this section, unless the context otherwise requires:

(1) "Capacity to consent" means the mental ability to make a rational decision, which includes the ability to perceive, appreciate all relevant facts and to reach a rational judgment upon such facts; or to make and carry out reasonable decisions concerning the person or the person's resources; or to protect the person from neglect, or hazardous or abusive situations without assistance;

(2) "Disabled adult" means a person who is eighteen (18) years of age or older and who meets one (1) of the following:

(A) Has some impairment of body or mind that makes the person unfit to work at any substantially remunerative employment;

(B) Lacks the capacity to consent;

(C) Has been certified as permanently and totally disabled by an agency of this state or the United States that has the function of so classifying persons; or

(D) Has been found to be incompetent by a court of proper jurisdiction; and

(3) "Elderly person" or "elder" means a person who is sixty (60) years of age or older who has some mental or physical dysfunctioning, including any resulting from age.

(b) In addition to other remedies provided by law, an elderly person or disabled adult in that person's own right, or by conservator or next friend, shall have a right of recovery in a civil action for compensatory damages for abuse or neglect, sexual abuse or exploitation as defined in this part or for theft of such person's or adult's money or property whether by fraud, deceit, coercion or otherwise. Such right of action against a wrongdoer shall not abate or be extinguished by the death of the elderly person or disabled adult, but shall pass as provided in § 20-5-106, unless the alleged wrongdoer is a family member, in which case the cause of action shall pass to the victim's personal representative.

(c) Jurisdiction for such action shall be in the circuit or chancery court where the elderly person or disabled adult may reside or where the actions occurred.

(d) Damages shall include compensatory damages and costs where it is proven that a defendant is liable for abuse or neglect, sexual abuse or exploitation as defined in this part or for theft of such elderly person's or disabled adult's money or property whether by fraud, deceit, coercion or otherwise. Costs shall include reasonable expenses. In addition, if it is proven upon clear and convincing evidence that abuse or neglect, sexual abuse or exploitation or theft resulted from intentional, fraudulent or malicious conduct by the defendant, a claimant shall be entitled to recover reasonable attorneys' fees. As part of any

judgment, the court may declare void and unenforceable any marriage proven to have been entered into as part of a scheme to commit abuse or neglect, sexual abuse or exploitation as defined in this part or theft of such elderly person's or disabled adult's money or property whether by fraud, deceit, coercion or otherwise.

(e) In addition to the damages described in (d), a defendant may also be found liable for punitive damages in accordance with applicable common law standards.

(f) Nothing in this section shall be construed as requiring the department of human services to initiate any proceedings pursuant to this section or to act on behalf of any elderly person or disabled adult subject to this section.

(g) This section shall not apply to a cause of action within the scope of title 29, chapter 26; such cause of action shall be governed solely by title 29, chapter 26.

(h) A financial institution, officer, director, or employee of a financial institution, shall not be liable in any civil action brought by or on behalf of a disabled adult or elderly person for recovery of damages under this chapter, unless prior to such civil action, the financial institution, officer, director, or employee of a financial institution, shall have been convicted of a violation of § 71-6-117; provided, however, that this provision shall not apply to theft or conversion by an employee, officer or director of a financial institution or liability arising under other provisions of law.

Credits

1999 Pub.Acts, c. 247, § 1, eff. May 27, 1999; 2000 Pub.Acts, c. 768, § 1 to 3, eff. May 22, 2000; 2004 Pub.Acts, c. 780, § 5, eff. July 1, 2004.

Notes of Decisions (3)

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-121

§ 71-6-121. Contact information for advanced-age victims of abuse, neglect, and exploitation; posting requirements; exemption

Currentness

(a) All offices of physicians licensed pursuant to title 63, chapter 6 or 9, all health care facilities licensed pursuant to title 68, chapter 11, all senior centers, all community centers and all pharmacies shall post the following in the main public entrance:

(1) Contact information including the statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office; and

(2) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect, and exploitation.

(b) The information listed in subsection (a) shall be posted on a sign no smaller than eleven inches (11″) in width and seventeen inches (17″) in height.

(c) All nursing homes, assisted living facilities and any other residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number.

(d) Any licensed nursing home that complies with the requirements of § 68-11-254 shall be exempt from the requirements of subsections (a) and (b).

(e)(1) All offices of physicians licensed pursuant to title 63, chapter 6 or 9, all health care facilities licensed pursuant to title 68, chapter 11, all community centers, and all pharmacies shall post in the main public entrance, on a sign no smaller than eight and one-half inches (8 ½ “) in width and eleven inches (11”) in height, a statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, or any other hotline that may be determined by the departments of health and commerce and insurance and communicated to health care providers subject to this section pursuant to subdivision (e)(2), with that number printed in boldface type, for immediate assistance.

(2) The departments of health and commerce and insurance, through the various regulatory and licensure boards with oversight of health care providers, shall include a statement notifying providers of the requirements of subdivision (e)(1) in the newsletters or other routine correspondences of such boards and shall post a copy of such statement on the departments' web sites. The statement shall include a contact telephone number for providers to request that a copy of the statement be mailed to them. Upon initial licensure, the various boards shall also provide initial licensees with the statement along with instructions for compliance with subdivision (e)(1).

(f) All offices of physicians licensed pursuant to title 63, chapter 6 or 9, all health care facilities licensed pursuant to title 68, chapter 11, all community centers, and all pharmacies shall post on a sign no smaller than eight and one-half inches (8 ½ ″) in width and eleven inches (11″) in height in the main public entrance a statement that a teen involved in a relationship that includes dating violence may call a national toll-free hotline, with that number printed in boldface type, for immediate assistance.

(g) Notwithstanding the provisions of subsections (a)-(f) regarding the size of the posters, physicians' offices, health care facilities, community centers and pharmacies are authorized to incorporate all of the information required in subsections (a)-(f) in a single poster at least eight and one-half inches (8 ½ ″) in width and fourteen inches (14″) in height that shall be posted in the main public entrance.

(h) The departments of health and commerce and insurance, through the various regulatory and licensure boards with oversight of health care providers, shall include a statement notifying providers of the requirements of subsections (a)-(g) in the newsletters or other routine correspondences of those boards and shall post a copy of the statement on the departments' web sites. The statement shall include a contact telephone number for providers to request that a copy of the statement be mailed to them. Upon initial licensure, the various boards shall also provide initial licensees with the statement along with instructions for compliance with subsections (a)-(g).

Credits

2004 Pub.Acts, c. 780, § 6, eff. Jan. 1, 2005; 2006 Pub.Acts, c. 804, §§ 1, 2, eff. July 1, 2007; 2007 Pub.Acts, c. 446, §§ 1, 2, eff. July 1, 2007.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-122

§ 71-6-122. Telephone service to report abuse, neglect, and exploitation

Currentness

The division of adult protective services of the department of human services shall establish a toll-free telephone service to enable citizens within the state to call the division free of charge to report abuse, neglect, or exploitation and to seek relevant assistance from the division in such matters.

Credits

2004 Pub.Acts, c. 780, § 7, eff. July 1, 2004.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-123

§ 71-6-123. Adult abuse, neglect, or exploitation; false reports

Currentness

(a) It is an offense for a person to report to the department an accusation of abuse, sexual abuse, neglect or exploitation of an adult if, at the time of the report, the person knows or should know the accusation is false.

(b) It is an offense for a person to knowingly cause another to report to the department an accusation of abuse, sexual abuse, neglect or exploitation of an adult if, at the time of the conduct, the person knows or should know the accusation is false.

(c) A violation of this section is a Class A misdemeanor.

(d) Notwithstanding the provisions of § 71-6-118 to the contrary:

(1) The department may report to the district attorney general or law enforcement authorities the identity of any person whom it reasonably believes has violated this section; and

(2) The information such person reported or caused to be reported may be disclosed and utilized in any manner necessary by the department, the district attorney general or law enforcement authorities as part of any investigation or prosecution of a violation of this section.

Credits

2008 Pub.Acts, c. 1005, § 1, eff. July 1, 2008.

Current through end of 2010 First Ex. Sess. and 2010 Reg. Sess.

End of Document

T. C. A. § 71-6-124

§ 71-6-124. Order of protection; petition; crimes and offenses

Currentness

(a)(1)(A) Any relative having personal knowledge that an adult has been the subject of a violation of § 71-6-117 or that such adult is threatened with or placed in fear of a violation of § 71-6-117 occurring against such adult may seek relief for the adult pursuant to this section by filing a sworn petition with any court with jurisdiction under this part alleging that the respondent has violated or threatens to violate § 71-6-117, regardless of the existence of any other remedy at law. For purposes of this section, "adult" shall not include a person while in the custody of intermediate care facilities for persons with mental retardation (ICF/MRs) and a person while receiving residential services or other services from a community provider through contracts with the division of intellectual disability services (DIDS), department of finance and administration.

(B) The petition must allege facts, based upon personal knowledge of the petitioner, that the adult lacks capacity to consent.

(C) Venue for a petition for an order of protection, and all other matters relating to orders of protection, shall be in the county where the respondent resides or the county in which the violation of § 71-6-117 occurred or is threatened to occur. If the respondent is not a resident of this state, the petition may be filed in the county where the adult resides.

(2) The court may enter an immediate ex parte order of protection against the respondent if the petition alleges upon personal knowledge of the petitioner, and the court finds in its ex parte order, that the adult lacks capacity to consent and is in immediate danger of abuse, neglect or exploitation or that the adult's property is being, is in immediate danger of being, or has been misappropriated by the respondent.

(3) The petition and any ex parte order issued pursuant to this section shall be personally served upon the respondent and the adult. If the respondent is not a resident of this state, the ex parte order shall be served pursuant to §§ 20-2-215 and 20-2-216.

(4) Written notice of the filing of the petition and copies of the petition and the ex parte order of protection against the respondent, if any, shall be sent by certified mail, return receipt to the adult protective services unit in the county office of department of human services in the county in which the petition is filed. The department shall have the right to intervene in the proceeding, but shall not otherwise be required to initiate any legal action as a result of such notice. The department may, at any time, file a petition pursuant to § 71-6-107 if it determines that the adult who is the subject of a petition for an order of protection is in need of protective services.

(5)(A) Within fifteen (15) days of service of an ex parte order of protection against the respondent, a hearing shall be held, at which time the court shall either dissolve any ex parte order that has been issued, or shall, if the petitioner has proved the adult lacks capacity to consent and the allegation of abuse, neglect or exploitation or the threat of such by a preponderance of the evidence, extend the order of protection for a definite period of time, not to exceed one hundred twenty (120) days, unless a further hearing on the continuation of such order is requested by the adult, the respondent or the petitioner; in which case, on proper showing of cause, such order may be continued for a further definite period of one hundred twenty (120) days.

(B) Any ex parte order of protection shall be in effect until the time of the hearing, and, if the hearing is held within fifteen

(15) days of service of such order, the ex parte order shall continue in effect until the entry of any subsequent order of protection is issued, proceedings under title 34, chapters 1-3, are concluded, or the order of protection is dissolved. If no ex parte order of protection has been issued as of the time of the hearing, and the petitioner has proven that the adult lacks capacity to consent and the allegation of abuse, neglect or exploitation of the adult or the threat of such by a preponderance of the evidence, the court may, at that time, issue an order of protection for a definite period of time, not to exceed one hundred twenty (120) days.

(C) The court shall cause a copy of the petition and notice of the date set for the hearing on such petition, as well as a copy of any ex parte order of protection, to be served upon the respondent and the adult at least five (5) days prior to such hearing. Such notice shall advise the respondent and the adult that each may be represented by counsel. The court may appoint a guardian ad litem under the provisions of § 34-1-107.

(D) Within the time the order of protection is in effect, any court with jurisdiction under this part may modify the order of protection, either upon the court's own motion or upon motion of the adult, the respondent or the petitioner.

(b) An order of protection granted pursuant to this section may:

(1)(A) Order the respondent to refrain from committing a violation of this part against an adult;

(B) Refrain from threatening to misappropriate or further misappropriating any moneys, state or federal benefits, retirement funds or any other personal or real property belonging to the adult; or

(C) Order the return to the adult or the adult's caretaker or conservator or other fiduciary any moneys, state or federal benefits, retirement funds or any other personal or real property belonging to the adult obtained by the respondent as result of exploitation of the adult or as result of any other misappropriation of such funds or property of the adult by the respondent. The court may enter judgment against the respondent for the repayment or return to the adult or the adult's caretaker, conservator or other fiduciary of any moneys, government benefits, retirement funds or any other personal or real property belonging to the adult that are under the control of or that have been obtained by the respondent as result of exploitation or misappropriation from the adult. Nothing in this subdivision (b)(1)(C) shall preclude an action under § 71-6-120. The court may, if the amount in question exceeds ten thousand dollars ($10,000), require any caretaker or custodian of funds appointed under this section to post a bond as required by § 34-1-105;

(2) Enjoin the respondent from providing care for an adult, on a temporary or permanent basis, anyone who the court finds has engaged in abuse, neglect or exploitation of an adult as defined in this part; in any situation involving the care of such adult, whether such actions occurred in an institutional setting, in any type of group home or foster care arrangement serving adults, and regardless of whether such person, facility or arrangement serving adults is licensed to provide care for adults;

(3) Prohibit the respondent from telephoning, contacting, or otherwise communicating with the adult, directly or indirectly; or

(4) Subject to the limitations otherwise stated in this section, grant any other relief deemed necessary by the court to protect an adult.

(c) All orders of protection shall be effective for a fixed period of time, not to exceed one hundred twenty (120) days. The court may modify its order at any time upon subsequent motion filed by any party together with an affidavit showing a change in circumstances sufficient to warrant the modification. The petitioner, respondent or adult, or the court on its own motion shall commence a proceeding under title 34, chapters 1-3 to determine whether a fiduciary should be appointed, if any party alleges that the conditions giving rise to the order of protection continue or may continue beyond the one hundred

twenty (120) days.

(d)(1) If the adult and the respondent have been served with a copy of the petition and notice of hearing, the order of protection shall be effective when the order is entered. For purposes of this subdivision (d)(1), an order shall be considered entered once a hearing is conducted and when such order is signed by:

(A) The judge and all parties or counsel;

(B) The judge and one (1) party or counsel and contains a certificate of counsel that a copy of the proposed order has been served on all other parties or counsel; or

(C) The judge and contains a certificate of the clerk that a copy has been served on all other parties or counsel.

(2) Service upon a party or counsel shall be made by delivering to such party or counsel a copy of the order of protection, or by the clerk mailing it to the party's last known address. In the event the party's last known address is unknown and cannot be ascertained upon diligent inquiry, the certificate of service shall so state. Service by mail is complete upon mailing.

(3) If the adult and the respondent have been served with a copy of the petition and notice of hearing, an order of protection issued pursuant to this part after a hearing shall be in full force and effect against the respondent from the time it is entered, regardless of whether the respondent is present at the hearing.

(4) A copy of any order of protection and any subsequent modifications or dismissal shall be issued to the petitioner, the respondent and the local law enforcement agencies having jurisdiction in the area where the adult resides. Upon receipt of the copy of the order of protection or dismissal from the issuing court or clerk's office, the local law enforcement agency shall immediately enter such order or dismissal in the Tennessee crime information system and take any necessary action to immediately transmit it to the national crime information center.

(5) Upon violation of an order of protection entered pursuant to this section, a court may order any appropriate punishment or relief as provided for in § 36-3-610.

(e)(1) It is an offense to knowingly violate an order of protection issued pursuant to this section. A law enforcement officer may arrest a respondent who is the subject of an order of protection issued pursuant to this section with or without warrant.

(2) In order to constitute a violation of this section:

(A) The person must have received notice of the request for an order of protection;

(B) The person must have had an opportunity to appear and be heard in connection with the order of protection or restraining order; and

(C) The court must have made specific findings of fact in the order of protection that the person committed a violation of this part.

(3) Any law enforcement officer shall arrest the respondent without a warrant if:

(A) The officer has proper jurisdiction over the area in which the violation occurred;

(B) The officer has reasonable cause to believe the respondent has violated or is in violation of an order for protection; and

(C) The officer has verified that an order of protection is in effect against the respondent. If necessary, the law enforcement officer may verify the existence of an order of protection by telephone or radio communication with the appropriate law enforcement department.

(4) Any person arrested for a violation of an order of protection entered pursuant to this section shall be treated as a person arrested for a violation of an order of protection issued pursuant to title 36, chapter 3, part 6.

(5) A violation of this subsection (e) is a Class A misdemeanor, and any sentence imposed shall be served consecutively to the sentence for any other offense that is based in whole or in part on the same factual allegations, unless the sentencing judge or magistrate specifically orders the sentences for the offenses arising out of the same facts to be served concurrently.

Credits

2010 Pub.Acts, c. 898, § 2, eff. May 10, 2010.

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